# DISABLED PERSONS PROTECTION COMMISSION INVESTIGATION REPORT

**NOVEMBER 21, 1988**

REGARDING DMH CORRECTIVE ACTIONS IN RESPONSE TO SIX WORCESTER STATE HOSPITAL DEATHS DURING THE PERIOD AUGUST 20, 1987 - JANUARY 14, 1988

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RE: DMH CORRECTIVE ACTIONS IN RESPONSE TO SIX WORCESTER STATE HOSPITAL DEATHS DURING THE PERIOD AUGUST 20, 1987 - JANUARY 14, 1988

Due to the requirements of the confidentiality laws of the Commonwealth, the names of the individuals whose deaths resulted in the actions reviewed in this report are represented by an initial. This conforms with similar usage in the investigation reports regarding the deaths which were issued to the public by the Department of Mental Health Office of Internal Affairs.

## INTRODUCTION

This investigation is conducted at the direction of the Commissioners of the Disabled Persons Protection Commission (DPPC) pursuant to M.G.L. c.19C, §8, which pertains to Commissioners' Investigations. The investigation was conducted by the Investigations Unit of the DPPC under the general supervision of Alexander F. Fleming, Executive Director of the Commission.

The focus of this investigation is twofold: first, to determine what actions have been recommended to, and taken by, the Department of Mental Health (DMH) to remedy the problems cited during a review of the six deaths, and second, to evaluate the progress made toward implementing these corrective actions.

This report provides the following information:

a. descriptions of the specific objectives and methodology of this investigation;

b. background information on the particular cases and the resulting investigations and corrective actions;

c. a summary of statements and/or recommendations by DMH, Secretary of Human Services Philip W. Johnston, Commissioner of

DMH Edward M. Murphy, the DPPC, and the Joint Committee on Human Services and Elder Affairs regarding the deaths;

d. Commission findings regarding implementation of or response to these recommendations; and;

e. conclusions and further recommendations by the Commission.

The section setting out the DPPC Findings is organized as follows: the statement or recommendation, followed by the response of DMH, followed by the DPPC Finding regarding the status or implementation of the corrective action cited in the DMH response.

The following terms used in this report are defined as follows:

- "corrective action statements" or "corrective action plans" or "action statements" refer to a specific DMH written statement prepared in response to the deaths at Worcester State Hospital which describes actions intended to eliminate or mitigate the problems related to the deaths. This document is required pursuant to 104 CMR 24.05(4)(a). By regulation, such statements are prepared by the person in charge of the facility where the particular incident occurred.

This report reviews and refers to certain materials:

1. Reports resulting from investigations into the deaths at Worcester State Hospital conducted by the Department of Mental Health Office of Internal Affairs. These investigations were conducted pursuant to the DMH regulations for investigations.(104 CMR 24.00)

2. A memorandum issued by Secretary Johnston to EOHS agency heads regarding emergency situations at state facilities, issued prior to completion of the DMH investigations. (see Appendix)

3. A series of recommendations made by the Commissioners of the DPPC to Secretary Johnston following a review of the DMH investigations of these cases. (see Appendix)

4. A letter sent by Senator John Houston and Representative Paul Kollios of the legislature's Joint Committee on Human Services and Elder Affairs to Commissioner Murphy outlining the committee's concerns regarding the deaths at Worcester State Hospital. (see Appendix)

5. A letter, dated August 25, 1988, from Commissioner Murphy to DPPC Executive Director Alexander F. Fleming, outlining the DMH response to the recommendations of the DPPC Commissioners. (see Appendix)

6. Corrective action statements issued by Linda Crumlin, the Acting Chief Operating Officer of Worcester State Hospital, following her review of the DMH investigations. (see Appendix)

7. A letter, dated September 20, 1988, from DPPC Director of Investigations Larry Wheeler to Ms. Crumlin, requesting documentation of DMH actions cited either by Commissioner Murphy in his letter to Mr. Fleming or Ms. Crumlin in her action statements. (see Appendix)

8. A letter, dated October 20, 1988, from Dale Chadwick, DMH Deputy Assistant Commissioner, to Larry Wheeler, responding to the DPPC documentation request of September 20, 1988. (see Appendix)

## CASE SUMMARIES

Mr. M., a 33 year-old patient, died on August 20, 1987 as a result of cardiac arrythmia secondary to an intraventricular septal defect. The DMH investigation report was completed on February 29, 1988 (DMH case no. 02-87-WOSH-086).

Mr. H., a 36 year-old patient, died on September 22, 1987 as a result of a seizure. The DMH investigation report was completed on February 23, 1988 (DMH case no. 02-87-WOSH-089).

Ms. J., a 34 year-old patient, died on October 21, 1987 due to aspiration pneumonia and aspiration of food stuffs. The DMH investigation report was completed on March 10, 1988 (DMH case no. 02-87-WOSH-103).

Mr. C., a 22 year-old patient, died on October 27, 1987, as a result of suicide by inhalation of gasoline vapors. The DMH investigation report was completed on April 7, 1988 (DMH case no. 02-87-WOSH-099/106).

Ms. P., a 42 year-old patient, died on January 1, 1988 from cardiac arrest secondary to respiratory arrest due to aspirations. The DMH investigation report was completed on April 7, 1988 (DMH case no. 02-88-WOSH-126).

Mr. E., a 78 year-old patient, died on January 14, 1988 from respiratory arrest due to pneumonia. The DMH investigation report was completed on April 6, 1988 (DMH case no. 02-88-WOSH-125).

## METHODOLOGY OF THIS REPORT

The overall methodology used to accomplish the two objectives of this investigation is straightforward. First, this report seeks to establish the scope of corrective action plans, and second, it seeks to evaluate the progress or lack thereof toward completing those plans.

In establishing the scope of its review, the Commission considered recommendations made by relevant parties as noted above. Both the Joint Committee on Human Services and Elder Affairs and the Secretary of Human Services expressed concerns or provided recommendations which were directly relevant to the topics covered by the initial DMH investigations, and this relevance required inclusion.

A series of interviews was conducted with senior management personnel at DMH. These individuals, who act directly upon problem areas cited by the DMH investigators, included Commissioner Murphy; Lou Berman, Assistant Commissioner for Hospital Management; Linda Crumlin, Acting Chief Operating Officer, Worcester State Hospital; Chris Healy, M.D., Chief of Psychiatry at Worcester State Hospital; Pat Bazemore, M.D., Chief of Medicine at Worcester State Hospital; and Errol Rambaran, Director of Staff Training at Worcester State Hospital.

A full review of each DMH investigation report was conducted. This included a review of each public investigation report, a review of each confidential investigation report, a review of the full appendices of each investigation report, and a review of the summaries of each interview conducted by the DMH investigators on each investigation. Approximately 6,000 pages of documentation were reviewed.

Where available, each DMH corrective action statement was compared to the findings of the DMH investigations to determine if they were consistent. The implementation of the requirements of the corrective action statements was assessed during announced and unannounced visits to Worcester State Hospital by Commission investigators. Documentation on each corrective action statement was requested and, if received, was reviewed. Corrective action plans were assessed for current progress, future goals, and likelihood of achieving those goals within specified timelines.

Also, the corrective action statements were reviewed for the appropriateness of the recommended actions and the likelihood that the actions would actually address the problems indicated.

## COMMISSION FINDINGS REGARDING DMH ACTIONS

### I. DMH INTERNAL AFFAIRS INVESTIGATIONS

The initial agency response to the deaths was the investigation by DMH pursuant to its regulations. The DPPC initial review of the DMH investigations noted that the DMH investigations were "extraordinarily thorough and detailed", that the DMH investigators approached their tasks with objectivity, and that the investigation reports were of high quality. The DPPC oversight of DMH abuse investigations provides a singular opportunity to gain a wide view of the quality of investigations. It is clear from the DMH reports, particularly in the amount of detail obtained, that these investigations were extraordinarily thorough, detailed, and objective.

However, it is important to note that the task of the DMH investigators is to ascertain the facts of cases and to make findings based on these facts. Such investigations are not intended to do more. (See Appendix, DMH manual on investigations.) The DMH investigation reports on the Worcester State Hospital deaths make no recommendations, nor do they make judgments about the circumstances in which these clients died. They simply present facts and conclusions based on those facts. Development of judgments regarding these findings and conclusions, and recommendations and actions to address the problems and issues raised by the judgments, are the task of management staff and, in particular, the person in charge of the facility.(See Appendix, DMH manual on investigations.)

### II. DPPC INITIAL RECOMMENDATIONS

In a letter dated May 19, 1988 to Secretary Philip W. Johnston (see Appendix), the DPPC Commissioners made six general recommendations following Commission review of six client death investigations - three at Worcester State Hospital and three at Bridgewater State Hospital. Secretary Johnston's response (see Appendix), dated June 3, 1988, was that he would forward the DPPC recommendations to Commissioner Murphy and Commissioner of Correction Michael Fair. The Secretary further stated that he had reviewed the investigations and had previously asked EOHS agency heads, via memo dated February 19, 1988 (see Appendix), to review emergency medical procedures and equipment.

Senator John Houston and Representative Paul Kollios, Chairmen of the Joint Committee on Human Services and Elder Affairs, in a letter dated August 8, 1988 (see Appendix), wrote to Commissioner Murphy. In that letter, among a number of concerns more fully addressed below, the chairmen supported the specific recommendations outlined by the DPPC, and urged that the recommended improvements be implemented immediately.

In a letter dated August 25, 1988, Commissioner Murphy wrote to Alexander Fleming, Executive Director of the DPPC, and outlined his response to the DPPC recommendations (see Appendix). On September 20, 1988, as part of the investigation for this report, DPPC Director of Investigations Larry Wheeler sent a letter to Linda Crumlin requesting documentation on the following six responses (see Appendix). Ms. Crumlin indicated in a telephone conversation on October 6, 1988 that this letter had not been received. The letter was sent by facsimile machine to Ms. Crumlin that same day. A response to the letter was received by Mr. Wheeler on October 20, 1988 from Ms. Dale Chadwick, a Deputy Assistant Commissioner in the DMH Hospital Management Division.

The Commission initial recommendations, the responses of Commission Murphy and Ms. Chadwick, and the DPPC findings are summarized as follows:

DPPC Recommendation 1

> The Commission recommended that all medical staff and staff in direct supervisory contact with patients at DMH state hospitals and at the Bridgewater State Hospital be thoroughly trained in CPR (Cardiopulmonary resuscitation) and recertified on a regular basis.

Commissioner Murphy responded as follows:

> "We concur with this recommendation. Presently, CPR training is offered at each facility as part of the orientation program for all new employees, or as part of an on-going educational program. Currently, physicians, many of whom are trained, are not part of this program and we agree that all medical staff should be included or evaluated in this training."
>
> "We have devised a plan to address these training needs. By September 1, 1988, at least two persons per shift will be CPR-certified. By November 1, 1988 the target is for 50% of all relevant staff to be CPR-

trained. By January 1, 1989 our goal is that all relevant staff will be CPR-trained."

"In addition, programs will be set up for the recertification process, where they do not currently exist. Periodic CPR training drills (Code Blue) will be instituted throughout the system."

**DPPC Finding:**

As a result of unannounced site visits on evenings and weekends, it has been demonstrated that at all surveyed times at least two physicians were on duty during all shifts, and that these people were trained in CPR. The objectives of 50% of all relevant staff to be CPR-trained by November 1, 1988 and 100% by January 1, 1989 cannot be completely evaluated at this time. It should be noted that as of our last site visit, September 16, 1988, many licensed nursing personnel had been CPR-trained. According to staff interviewed during both announced and unannounced site visits, mock "Blue Day" code drills were performed on a monthly basis. Dr. Pat Bazemore, Chief of Medicine, in an interview conducted on September 16, 1988, indicated that the number of physicians (medical doctors including psychiatrists) on duty between the hours of 6:00 PM and 7:00 AM is now set at two. Additionally, an alternate is designated on a daily basis and that person is on-call in case of an absence.

In the DPPC documentation request, dated September 20, 1988, the DPPC requested supporting documentation on this point, specifically: "That as of September 1, 1988 at least two persons per shift have been certified in CPR. Please include also your plans for ensuring that 50% of staff will be CPR trained by November 1, 1988 and that all staff will be CPR trained by January 1, 1989."

Ms. Chadwick's response of October 20 is as follows: "1. Two persons per shift have been trained in CPR. Ninety-seven percent of all licensed staff have been trained, all physicians have been trained and two of these physicians are present at the hospital 24 hours/day, 7 days/week. Documentation of these sessions and listings of attendees is available at the hospital."

DPPC Recommendation 2

The Commission recommends that all DMH state hospitals and the Bridgewater State Hospital be equipped at all times with the necessary

emergency medical equipment that will enable a physician to adequately respond to such medical emergencies.

Commissioner Murphy responded as follows:

"We concur with your recommendation that adequate medical equipment must be available for medical emergencies. Presently, all hospitals have either crash carts, or emergency response kits that include equipment and drugs. These will be reassessed on their adequacy and effectiveness, based on standardized expectations being drafted by the Directors of Nursing from our hospital system."

**DPPC Finding**

DMH regulations 104 CMR 2.11(8) [revised January 1, 1983] state that emergency first aid kits shall be available on each ward and that they shall minimally contain, "airways, bandages, tourniquet, antiseptics and ambu bags."

During announced and unannounced site visits the existence of crash carts on every floor was verified. Crash carts contained considerably more equipment than required in the regulations for emergency response kits. In no instance during these visits was a crash cart not available.

The DPPC requested documentation, specifically "That equipment for medical emergencies has been reassessed for adequacy and effectiveness."

Ms. Chadwick's response is as follows: "The enclosed crash cart checklist is completed and monitored monthly by the nursing staff." (See Appendix for copies of checklist.)

DPPC Recommendation 3

The Commission recommended that all medical doctors in DMH state hospitals receive a full and adequate training program in basic lifesaving procedures, on responding to medical emergencies, and in DMH regulations on medication administration and restraint procedures.

Commissioner Murphy responded to this as follows:

"We concur with this recommendation, however, we believe a clarification is needed on the issue of DMH regulations regarding the use of PRN (as needed) psychotropic medication. PRN psychotropic medications can be prescribed, but cannot be used as a chemical restraint. A psychotropic drug used as a chemical restraint must have a separate medication order as well as being documented on the seclusion and restraint form."

"Your point is well taken in terms of the necessity of all physicians, as well as physicians in training, to be required to have training in (1) CPR; (2) DMH Seclusion and Restraint regulations; and (3) Violence Management Training and this will be accomplished where not already in place by October 1, 1988."

**DPPC Finding:**

According to Mr. Errol Rambaran, Director of Training and education, as of September 16, 1988, 90% of all physicians are BLS-certified (Basic Life Saving including CPR) and the remaining 10% will be certified within two months. The BLS course is taken directly from a Red Cross curriculum. As described by Mr. Rambaran, not all physicians will be CPR-trained by October 1, 1988. However, it should be noted that this objective is due to be completed by mid-November and was 90% complete by September 16, 1988.

The September 20 DPPC request specifically requested documentation "That by October 1, 1988 physicians in training will be knowledgeable of DMH regulations as regards the administration of psychotropic regulations, trained in DMH Seclusion and Restraint regulations and trained in Violence Management."

Ms. Chadwick's response is as follows: "Physician training in DMH regulations is ongoing. Ms. Crumlin will provide more detailed information by the second week in November."

DPPC Recommendation 4

The Commission recommends that at DMH state hospitals, and at Bridgewater State Hospital, procedures for declaring a medical emergency include the simultaneous notification of an ambulance service.

Commissioner Murphy responded to this recommendation as follows:

"We concur with this recommendation and will facilitate that this procedure be included in each hospital's emergency plan. We will, in addition, reassess this plan to determine whether we are using the most effective process for our medical emergencies."

**DPPC Finding:**

In an interview with Commissioner Murphy on July 7, 1988, he stated that he would establish a task force to be composed of psychiatrists, medical experts and DMH staff to address two principle questions:

1). What is the level of medical care that should be available in a psychiatric facility? and

2). What is the level of emergency medical response that should be available in a psychiatric facility?

According to Dale Chadwick in a phone conversation on October 21, 1988, the task force members have been appointed, the task force has met, and it is addressing the issues outlined above.

The DPPC requested documentation, specifically, "That simultaneous notification of the ambulance service has been included in the emergency plan and that the emergency plan itself has been reassessed in terms of its effectiveness."

Ms. Chadwick's response included a copy of a Worcester State Hospital Ambulance and Emergency Response policy dated July 20, 1988 (see Appendix). This outlines procedures for notifying an ambulance service in the event of "cardiac arrest, respiratory arrest, choking episode, or other immediately life-threatening event."

DPPC Recommendation 5

The Commission recommends that it should be notified of all client deaths, natural or otherwise, at the time of the original report.

Commission Murphy's response to the recommendation is as follows:

"We concur with this recommendation and will issue to the Commission a written copy of each death report as it is received by the Division of Hospital Management. This will be issued through the Office of Internal Affairs."

**DPPC Finding:**

As of the date of Commissioner Murphy's letter, August 25, 1988, the Commission has no evidence to indicate that this procedure is not being followed. The Commission has received reports of client deaths both in and out of facilities under the Hospital Management Division. The Commission has not found a case in which it has not been notified of a death since August 25, 1988.

The DPPC request on this point sought documentation, "That the DPPC has been provided with a report of each patient who has died at Worcester State Hospital since August 25, 1988."

Ms. Julie Fay, Chief of Staff for Commissioner Murphy, stated in early November that all death reports will be reported to the Commission and that this has been the policy of DMH since August 25.

DPPC Recommendation 6

The Commission recommends that the need for interpreters and communication disorder specialists be assessed at all facilities, including English, foreign languages, sign language for the deaf and hard of hearing, and other communication systems.

Commissioner Murphy's response to the recommendation is as follows:

"Presently we do have bilingual staff who are being utilized. Each facility will be sent a copy of this recommendation and assess their current capacity, we will then devise an appropriate plan to address this need in FY'89."

**DPPC Finding:**

The DPPC requested documentation "That the need for for translators available for patients with communication disorders or who do not speak English will be assessed."

Ms. Chadwick's response to this request states, "Ms. Crumlin is assessing the need for communication disorder specialists. She will provide the results of her assessment by the second week of November."

The Commission has no further evidence to indicate whether or not this recommendation has been implemented.

## III. LETTER TO DMH FROM THE JOINT COMMITTEE ON HUMAN SERVICES AND ELDER AFFAIRS

In a letter to Commissioner Murphy dated August 8, 1988, the Committee raised several concerns regarding the deaths at Worcester.

Record keeping:

[Committee] "At least five of the six investigation reports we received noted serious deficiencies in documentation by staff, including other medical and mental health professionals and direct care staff, of resident's progress, condition and/or treatment. It seems reasonable to conclude - as is also suggested by other testimony we have received - that inadequate note-taking and record-keeping are a recurrent problem. The reasons for important treatment decisions have been inadequately documented; residents' notes for shifts or even days at a time, prescriptions and medical information have been recorded incorrectly, and so on. There needs to be a clear policy for all relevant staff regarding such documentation, and this policy must be enforced by management, perhaps through periodic audits of such records. A peer review system, as has already been discussed, would also help to address this problem as it pertains to documentation by professional employees."

**DPPC Finding:**

According to the corrective action statement by Linda Crumlin, Acting Chief Operating Officer at Worcester State Hospital, issued

Services has instructed the chiefs of discipline and the clinical directors to insure adequate documentation of all significant events."

Ms. Chadwick's October 20 response is as follows,

> "Ms. Crumlin will provide information relating to medical record keeping by the second week of November."

The Commission has received no further information to indicate whether or not the recommendation has been implemented.

Medication Choice:

[Committee] "Your expert consultants found drug prescriptions in at least three of the cases investigated to be questionable at best. Again, a peer review process would be one way of avoiding such serious errors."

**DPPC Finding:**

According to the action statement of Linda Crumlin regarding Mr. H. dated August 3, 1988, (Investigation #02-87-WOSH-089),

> "The Chief of Psychiatry will specify and define hospital-wide protocol for psychopharmalogical consultations."
>
> "With regard to monitoring effective level of medication, the Chief of Psychiatry and the Chief of Medicine will ensure that staff physicians are trained regarding monitoring of the effective levels of medication and that these sessions be documented."

The DPPC then requested documentation to support these statements, specifically that, "the Chief of Psychiatry and the Chief of Medicine have ensured that staff physicians are trained regarding the monitoring of effective levels of medication and that these training sessions are documented."

Ms Chadwick's October 20 response to this DPPC request is as follows,

> "Ms. Crumlin and Dr. Barreira are developing a Psychiatry Policy Manual which will address medication monitoring,

August 3, 1988, regarding the death of Mr. C. (investigation #02-87-WOSH-086), "The Director of Clinical and Professional Services has instructed the Chiefs of Discipline and the Clinical Directors to ensure adequate documentation of all clinically relevant data. The adequacy of documentation will also continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization ."(PSO)

According to the action statements by Linda Crumlin on all six Worcester deaths,

> "The Chief of Medicine has instituted a policy and procedure which requires physicians leaving the hospital to note in a book any patients with acute medical illnesses. The physicians coming on duty are required to review this book in the admissions office."
>
> "The Chief of Medicine has required a daily progress note on any hospital patient with an active medical problem."
>
> "The Director of Nurses is to review the circumstances surrounding the medication error and take appropriate action, including, at least, the following:
>
> > a. review of medication administration policies to ensure they comply with all nursing care standards.
> >
> > b. ensure that all nursing staff are adequately trained and that they carry out these policies according to applicable standards."
>
> "The Director of Nurses will develop a policy regarding regular assessment of patients' health status and actions to be taken to ensure adequate communication/documentation of changes to the physicians and to other nurses at shift changes."

On September 20, the DPPC requested documentation to support the above statements, specifically that, "the chiefs of discipline and the clinical directors are ensuring adequate documentation of all clinically relevant data and that the adequacy of documentation is being monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization" and that "the Director of Clinical and Professional

criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to be available for circulation this winter."

The Commission has received no documentation to indicate whether or not the recommendation has been implemented.

Continuity of Care:

[Committee] "Judging from conclusions reached in one of the investigations, staff at Worcester State Hospital received inadequate preparation for the ward reorganization which took place there. It is incomprehensible that a state hospital resident - particularly one in as tenuous condition as the woman in question - would be moved to a new ward without even a transfer summary or any continuity of staff contact. There must be a firm policy to assure that such handling of resident transfers and staff reassignment will not be tolerated."

**DPPC Finding:**

Within the six actions statements issued by Ms. Crumlin there are no provisions which specifically address this point. There are a number of statements pertaining to record keeping which indirectly address this concern. The Commission is not aware of any plans to further re-organize units at Worcester State Hospital.

Organization of Staff Responsibilities:

[Committee] "The lack of pre-assigned roles to various staff members during emergencies resulted in delays and inefficiency in handling life-threatening situations. Emergency procedures must be practiced regularly and specific roles of staff - with the necessary amount of flexibility - should be planned.

"In addition, there appears to be a pattern of vagueness in determining what staff member(s) will take primary responsibility for monitoring a specific resident - particularly when a resident is medically ill - and following other kinds of medical orders such as dispensation of additional fluids. In one case, there was confusion over which staff member was responsible for notifying a resident's daughters of their appointment as guardians, resulting in the daughters not being notified."

**DPPC Finding:**

In the Commission's investigative interview with Linda Crumlin on July 20, 1988, Ms. Crumlin indicated pre-assigned roles for code team staff were being considered, but had not been deemed to be the most efficient method at that time. Throughout announced and unannounced visits which continued until September 16, 1988, the DPPC investigators found that code response trainings were still being conducted in "gaggle" fashion, i.e., all flock to the scene at once and a leader is then designated by the group. In Ms. Crumlin's decision and action statement on the investigation regarding Ms. P., (investigation #02-88-WOSH-126), dated October 3, 1988, it is stated that,

> "The Director of Medicine is working with the staff from the University of Massachusetts Medical Center in order to establish a code team approach to emergency response at Worcester State Hospital and revise emergency medical response policies to reflect this approach."

In addition to the action cited above, Ms. Crumlin stated that the following actions will be taken:

> "The Director of Clinical and Professional Services is to instruct the appropriate Chiefs of Discipline and Clinical Directors to provide training to all appropriate treatment team members regarding standards of adequate and appropriate communication between families and treatment team members. These training sessions are to be documented through Staff Development."
>
> "The Director of Nurses will develop a fluid intake/output policy for nursing services and ensure that all nursing staff are trained in and carry out this policy."

<u>Material Resources/Physical Plant</u>

[Committee] "It is our understanding that the availability of emergency medical equipment is being improved, and we again urge that such improvements be undertaken on a system-wide basis and not only at WSH."

"We are also concerned about the poor lighting noted at WSH and the deficiencies in fire safety noted at a number of state hospitals. Recent

reports have identified building deficiencies with respect to safety codes at all seven state hospitals. Surely, these problems can be rectified through the capital outlay program."

**DPPC Finding:**

These areas were not addressed by either the DPPC investigators or by any specific corrective action statement issued by Ms. Crumlin.

Disciplinary Action:

[Committee] "We do not wish to see direct care staff scapegoated for problems that result, at least partially, from the conditions in which they work and from failures of management. However, there needs to be greater accountability of all levels of staff, including management, for errors in the care of clients entrusted to them. There were a number of indefensible staff actions uncovered by your investigations, and it is not clear whether these have been appropriately addressed. Consumers, families, and the advocates frequently express concern to us about improper and/or inadequate staff actions, and we are concerned that there is not a sufficient response when such problems occur."

**DPPC Finding:**

During interviews with DPPC investigators it was noted by Commissioner Murphy, Assistant Commissioner Berman, and Acting Chief Operating Officer Linda Crumlin that one medical doctor involved in the deaths had been asked to resign and had done so; also that a second medical doctor has been asked to resign and has been relieved of all emergency response duties. As has been noted in testimony to the Joint Committee by Commissioner Murphy, former Chief Operating Officer Edward Riquier has been reassigned to the DMH central office.

DPPC investigators have no evidence of any further disciplinary or other actions taken with respect to the Worcester State Hospital staff. Interviews with direct care staff during announced and unannounced visits do not indicate any evidence that direct care staff have been disciplined as a result of actions in these six deaths.

## IV. MEMORANDUM FROM SECRETARY JOHNSTON DATED FEBRUARY 19, 1988

In his June 3, 1988 response the Commission, Secretary Johnston notes a memo to agency heads, dated February 19, 1988, which cited concerns about the quality of emergency medical response. In the February memo Secretary Johnston addressed four particular concerns and requested that agency heads inform him as to the status of each. Outlined below are the four concerns raised by Secretary Johnston and the response to each, as found by the DPPC review.

Concern 1:

> Facilities did not have a specific team of trained staff to respond to emergency calls.

**DPPC Finding:**

> As noted above, until the October 3, 1988, corrective action statement by Linda Crumlin, the DPPC investigators found no evidence of a specific team of trained staff for emergencies.

Concern 2:

> Doctors, nurses and other staff were not certified in Advanced Cardiac Life Support (ACLS) or Basic Life Support (BLS) which require annual training and recertification.

**DPPC Finding:**

> As noted above, according to the Mr. Rambaran, Director of Staff Training at Worcester State Hospital, 90% of medical doctors are trained in CPR and the remaining 10% will be trained by mid-November.
>
> The following items are contained in action statements issued by Ms. Crumlin:
>
> > "Mock blue day training has been initiated and occurs on all three shifts."
> >
> > "All nursing staff are required to be trained in basic life support level of emergency response. All general medical physicians

are required to be trained in advance cardiac life support level of emergency response."

"All nursing staff have been informed of the expectation that they are to provide a basic life support level of response to medical emergency situations."

"Ongoing training of staff in CPR, BLS, crash carts, airway management and other emergency response procedures." [sic]

On September 20 the DPPC requested documentation on the following matters:

First, that, "mock blue day drills have been initiated and are ongoing on each shift. Please note the frequency of drills.";

second, that, "staff is being trained in CPR, CLS, crash carts, airway management and emergency response procedures";

third, that, "all medical physicians are required to be certified in both BLS and ACLS. Specifically, this office requests a copy of the initial report that was to have been submitted no later that September 3, 1988 to the Chief Operating Officer reflecting the status in certification of all medical physicians"; and

fourth, that, "all licensed nursing staff are requested to be BLS-trained. Specifically this office requests a copy of initial report that was to have been submitted no later that September 3, 1988 to the Chief Operating Officer reflecting the status in certification of all nursing staff."

Ms. Chadwick's October 20 response to this request is as follows,

"Per the enclosed Interim Draft Policy of Emergency Medical Response, the Department at this time is prepared to mandate BLS. The Department is working with representatives from the Massachusetts Psychiatric Society and an Internal Medicine consultant to assess the feasibility of mandating ACLS certification of all medical physicians. The enclosed policy does not limit a facility to BLS and at Worcester, all Internal Medicine physicians have received ACLS training. A final policy will be issued as soon as the MPS completes its final study, anticipated this fall."

She also states, "Almost all of the nursing staff are BLS-trained. Ms. Crumlin expects to complete this training this fall."

Ms. Chadwick also refers to a memo from Assistant Commissioner Lou Berman to Commissioner Murphy, dated August 8, 1988 (see Appendix), in which Mr. Berman states that, since January 1, 1988, there have been 49 training sessions for CPR resulting in 288 individuals trained, 19 sessions in crash cart management with 71 individuals trained, and one 'blue day' practice alert per shift per month.

Concern 3:

Standard equipment needed to conduct proper CPR was not available.

**DPPC Finding:**

The DMH investigations conclude that certain pieces of emergency medical equipment were not present on crash carts at Worcester State Hospital. In a decision and action statement issued by Ms. Crumlin on August 3, 1988, she stated that several actions were taken including "obtaining additional medical equipment to support emergency response efforts." In an October 3, 1988 corrective action statement Ms. Crumlin stated that "Additional medical equipment has been purchased to support the provision of quality medical care."

Concern 4:

"Crash carts" containing necessary supplies were not properly stocked.

**DPPC Finding:**

As noted above in the DPPC finding regarding Concern #3, the DMH investigations conclude that certain pieces of emergency medical equipment were not present on crash carts at Worcester State Hospital. In a corrective action statement issued by Ms. Crumlin on August 3, 1988, she stated that several actions were taken including "obtaining additional medical equipment to support emergency response efforts." In a October 3, 1988 corrective action statement Ms. Crumlin stated that "Additional medical equipment has been purchased to support the

provision of quality medical care." In DPPC investigators' visits, there were no occasions noted when crash carts were not fully stocked.

## V. ACTIONS BY COMMISSIONER MURPHY

### Establishment of a Task Force

In the interview with Commissioner Murphy on July 7, 1988, as previously stated, he indicated that there were two principal policy questions which he felt needed to be addressed as an outcome of the Worcester investigations:

1) What is the level of general medical care that should be provided in a mental health facility? and

2) What is the level of emergency medical treatment that should be available in a mental health facility?

The Commissioner indicated that he would establish a task force of prominent medical and psychiatric experts to address these concerns.

**DPPC Finding:**

In a telephone interview with Deputy Assistant Commissioner Dale Chadwick on October 21, 1988, Ms. Chadwick indicated that task force members have been appointed, the task force has met, and it is pursuing the objectives outlined by Commissioner Murphy. Among others, appointees include medical experts and members of the Massachusetts Psychiatric Association .

## VI. ACTIONS BY LINDA CRUMLIN

Ms. Crumlin, as the Acting Chief Operating Officer of Worcester State Hospital and the person in charge of the facility for purposes of DMH investigation regulations, issued a number of detailed and comprehensive corrective action statements on the six deaths. These are included in the appendices. Outlined below are the specific actions recommended on each death and the findings found by DPPC investigators regarding implementation of or compliance with the actions contained in Ms. Crumlin's statements.

In the corrective action statements on the deaths of Mr. H, Ms. J, and Mr. M., Ms. Crumlin states that she has taken six specific actions. These six appear in each statement and are addressed below. Further individual recommendations and actions follow.

Joint Actions Resulting from the deaths of Mr. H., Ms. J., Mr. M.:

Action [1]:

The number of physicians on duty evenings and weekends has been increased to two.

**DPPC Finding:**

As confirmed by the DPPC's announced and unannounced visits, there were two physicians on duty at all surveyed times. As noted above, according to Dr. Bazemore, a back-up system has been introduced to assure availability of medical doctors.

Action [2]:

Mock blue day drills were initiated and are ongoing on each shift.

**DPPC Finding:**

From all information available to the DPPC investigators, mock blue day drills have been initiated and appear to be ongoing on each shift at least one time each month.

The DPPC requested documentation on this point, specifically that "mock blue day drills have been initiated and are ongoing each shift. Please note the frequency of drills."

The response from Ms. Chadwick refers to a memo from Lou Berman, Assistant Commissioner for Hospital Management dated August 8, 1988, in which he states that Linda Crumlin has informed him that one blue day practice alert per shift per month has been performed since January 1, 1988.

Action [3]:

Continuing training of staff in cardiopulmonary resuscitation (CPR), Basic Life Saving (BLS), crash carts, airway management and emergency response procedures.

**DPPC Finding:**

As noted above, and as found by DPPC investigators, training in the above areas is continuing. The DPPC also requested documentation on this matter, specifically that, "staff is being trained in CPR, BLS, crash carts, airway management and emergency response procedures."

Ms. Chadwick in her response refers to Mr. Berman's August 8, 1988 memo in which he states that since January 1, 1988, 49 training sessions for CPR have occurred resulting in 288 individuals trained, and 19 training sessions in crash cart management in which 71 individuals have been trained.

Action [4]:

All medical physicians are required to be certified in both BLS and Advanced Cardiac Life Saving (ACLS).

**DPPC Finding:**

As noted above, the Director of Staff Training indicates that 90% of medical doctors are BLS-trained and that the remaining 10% will be trained by mid-November. The DPPC investigators have found no evidence that this is not accurate. The DPPC requested documentation on this point, specifically that "all medical physicians are required to be certified in both BLS and ACLS. Specifically, this office requests a copy of the initial report that was to have been submitted no later than September 3, 1988 to the Chief Operating Officer reflecting the status in certification of all medical physicians."

Ms. Chadwick in her response indicates that at Worcester, "all Internal Medicine physicians have received ACLS training."

Action [5]:

All licensed nursing staff are required to be BLS-trained.

**DPPC Finding:**

The DPPC investigators cannot substantiate that all nursing staff have been trained in BLS. On announced and unannounced site visits, all nurses questioned have indicated that they are BLS-trained. The DPPC requested documentation on this matter, that "all licensed nursing staff are required to be BLS-trained. Specifically, this office requests a copy of the initial report that was to have been submitted no later than September 3, 1988 to the Chief Operating Officer reflecting the status in certification of all nursing staff."

Ms. Chadwick's response is as follows: "Almost all of the nursing staff are BLS trained. Ms. Crumlin expects to complete this training this fall."

Action [6]:

Obtaining additional medical equipment to support emergency response efforts.

**DPPC Finding:**

The DPPC investigators reviewed crash carts during some site visits. During these visits there is no evidence to indicate that they were not fully stocked. Regarding ordering of emergency medical equipment, the DPPC has been unable to locate or track any documentation of requests, or approvals for funding for such purchases, despite repeated requests to the DMH Division of Hospital Management for such information.

<u>Actions resulting from the death of Mr. H.:</u>

Action [1]:

"The Director of Clinical and Professional Services has instructed the Chiefs of Discipline and the Clinical Directors to ensure adequate documentation of all clinically-relevant data. The adequacy of documentation will also continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization."

**DPPC Finding:**

The DPPC investigators have not reviewed records of current patients at Worcester State Hospital. Documentation to support the above statement was requested on September 20. In the letter from Ms. Chadwick dated October 20 she states that "Ms. Crumlin will provide information relating to medical record keeping by the second week of November".

Action [2]:

"Policy directives have been issued requiring all medical physicians to be certified in basic life support and advance cardiac life support. All nursing staff are to be certified in basic life support. The Chief of Medicine and the Chief of Nursing are to provide to the Chief Operating Officer (through the office of staff development) quarterly updates specifying status of certification of all medical physicians and nurses. An initial report for all current medical physicians and nurses is to be submitted to the Chief Operating Officer no later than September 3, 1988. The Office of Staff Development is responsible for tracking and monitoring this training. The Director of Nurses is to work with the Office of Staff Development to establish a training schedule for all nursing staff and specify the date by which all nurses will have been certified."

**DPPC Finding:**

As noted above, Ms. Chadwick, in her letter, states that most nursing staff are BLS-trained and that training is expected to be completed this fall. She also states that "Per the enclosed Interim Draft Policy of Emergency Medical Response, the Department at this time is prepared to mandate BLS. The Department is working with representatives from the Massachusetts Psychiatric Society and an Internal Medicine consultant to assess the feasibility of mandating ACLS certification of all medical physicians. The enclosed policy does not limit a facility to BLS and at Worcester, all Internal Medicine physicians have received ACLS training. A final policy will be issued as soon as the MPS completes its study, anticipated later this fall."

As noted in site visits, DPPC investigators found no nursing staff not trained in BLS. As noted above, the Director of Staff Development indicated that 90% of doctors have been BLS-trained, the remaining

10% to be trained by mid-November. As of September 16, 1988, Mr. Rambaran indicated that 50% of physicians were ACLS-qualified. Mr. Rambaran stated that such training is scheduled outside the institution due to the fact that advanced cardiac equipment is not utilized at Worcester State Hospital.

Actions resulting from the death of Ms. J.:

Action [1]:

"The Chief of Medicine and the Chief of Psychiatry have been asked to define with the appropriate Service Directors and Program Directors criteria for medical and psychiatric intervention. In addition, the frequency by which all patients are to be seen by medical physicians and psychiatrists will be established."

**DPPC Finding:**

In her letter of October 20, Ms. Chadwick stated as follows: "Ms. Crumlin and Dr. Barreira are developing a Psychiatry Manual which will address medication monitoring, criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to be available for circulation this winter."

Action [2]:

"The Director of Nurses has been asked to retrain nursing staff on criteria for notifying appropriate medical personnel regarding changes in patients medical or psychiatric condition."

**DPPC Finding:**

The letter of Ms. Chadwick addressed this concern, as set out in the above finding, indicating that a Psychiatry Manual which will address this issue will be available this winter.

Action [3]:

"The Chief of Psychiatry will specify and define hospital-wide protocol for psychopharmacological consultations."

**DPPC Finding:**

The letter of Ms. Chadwick addressed this concern, as set out in the finding to Action [1] above, indicating that a Psychiatry Manual which will address this issue will be available this winter.

Action [4]:

"The Director of Clinical and Professional Services has instructed the chiefs of discipline and the clinical directors to insure adequate documentation of all significant events. The adequacy and quality of documentation will also continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization."

**DPPC Finding:**

In the letter from Ms. Chadwick dated October 20 she states that "Ms. Crumlin will provide information relating to medical record keeping by the second week of November".

Action [5]:

"The Director of Nurses has been instructed to insure that all licensed nursing personnel receive basic life support training."

**DPPC Finding:**

In Ms. Chadwick's response to this request she states, "Almost all of the nursing staff are BLS trained. Ms. Crumlin expects to complete training this fall."

As noted, in site visits the DPPC investigators found no nursing staff not trained in BLS when questioned. The DPPC requested documentation on this point, specifically "that all licensed nursing staff are required to be BLS trained. In particular, this office requests a copy of the initial report that was to have been submitted no later than September 3, 1988 to the Chief Operating Officer reflecting the status in certification of all nursing staff."

Action [6]:

"The Chief of Medicine has developed protocol for physicians outlining the hospital's procedures, code calls and emergency requirements."

**DPPC Finding:**

The DPPC has no information at the time of this report to support the above statement.

Action [7]:

"The Chiefs of nursing, medicine and psychiatry, through a copy of this letter, are instructed to report to me for the case file within 30 days of [August 3], the status of all assigned actions required by this report."

**DPPC Finding:**

The DPPC has received no documentation at the time of this report to support the above statement.

Actions resulting from the death of Mr. M.:

Action [1]:

"With regard to seizure precaution policies, the Chief of Medicine and the Director of Nurses have been instructed to review the seizure precaution policy to ensure that specific criteria exist which identifies under what circumstances patients with a history of seizures require seizure precautions."

DPPC Finding:

The DPPC requested documentation on this matter, specifically that "the Chief of Medicine and the Director of Nurses have ensured that specific criteria exist that identify under what circumstances patients with a history of seizures require seizure precautions."

In response to this request, Ms. Chadwick refers to a draft seizure policy dated July 19, 1988 (see Appendix) and states, "Ms. Crumlin

will provide a final policy as soon as it is completed, expected to be the end of November."

Action [2]:

"With regard to bed check policy, the Director of Nurses has instructed all staff to follow the bed check policy and to document these checks."

**DPPC Finding:**

Based upon information gathered during site visits, there are clear indications that the bed check policy is not being implemented. Face checks were not conducted according to policy on DPPC visits on 7/27/88 and 8/28/88, nor were standard operating procedures regarding face checks available to staff. The DPPC requested documentation on this point, specifically that "the Director of Nurses has instructed all staff to follow the bed check policy and to document these checks."

In response to this request, Ms. Chadwick states,

"A draft department policy for security (patient bed checks) is being written. This preliminary draft will be circulated this fall. We will forward a copy once it is ready for circulation."

Enclosed in the documentation forwarded to the DPPC is a memo dated July 11, 1988 from Anne Ranaghan, Acting Director of Nurses, to Assistant Directors of Nurses stating that BLS certification is required of all licensed staff (see Appendix). Also included is a memo dated July 21, 1988 from Errol Rambaron, Director of Staff Development, to Linda Crumlin, in which he states that 90 nurses have been certified in CPR and 30 remain to be certified (see Appendix).

Action [3]:

"With regard to medication documentation, the Director of Nurses will retrain all nursing staff in maintaining medication and treatment sheets in a safe and secure setting. In addition, the Director of Quality Assurance has been authorized and instructed to obtain and seal the record of any patient who expires at Worcester State Hospital. The entire medical record and other documents including medication sheets and cardex shall be secured by the medical records department

through the Director of Quality Assurance. The Director of Medical Records will develop a policy specifying appropriate procedures for sealing medical records."

**DPPC Finding:**

The DPPC requested documentation on this matter, restating the specific recommendation set out above. In response, Ms. Chadwick indicated that Ms. Crumlin would supply this information by the second week in November.

Action [4]:

"With regard to monitoring the effective levels of medication, the Chief of Psychiatry and the Chief of Medicine will ensure that staff physicians are trained regarding the monitoring of effective level of medication and that these (sessions) are documented."

**DPPC Finding:**

In an interview on September 16, 1988, Dr. Pat Bazemore, Chief of Medicine indicated that medication orders are reviewed on a monthly basis and, upon any clinical change, a pharmacy consultant was available for a three month period; further, that there are plans to implement a policy for monitoring medications. The Chief of Psychiatry, Dr. Healy, stated in an interview on September 16, 1988, that the memorandum regarding this subject came out the week before and has not been addressed at that time. He also stated that medication monitoring is discussed at monthly meetings, that a computer system alerts physicians to patients who are on two or more of the same type of medication, and plans exist to develop a policy on medication monitoring.

The DPPC requested documentation on this matter, specifically that "the Chief of Psychiatry and the Chief of Medicine have ensured that staff physicians are trained regarding the monitoring of effective levels of medication and that these training sessions are documented."

In response to this request, Ms. Chadwick states that "Ms. Crumlin and Dr. Barreira are developing a psychiatry Policy Manual which will address medication monitoring, criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to the available for circulation this winter."

Action [5]:

"Regarding the physician who responded to the emergency: Upon review of this case by the Chief of Medicine on 9/29/87, it was found that the physician had not been trained in basic life support or cardiac life support. Therefore, the physician was assigned to attend training to ensure certification in advanced cardiac life support. ACLS training was made mandatory for all physicians. The physician received certification in advanced cardiac life support in December of 1987."

**DPPC Finding:**

The DPPC requested documentation on this point, and was informed as follows:

Ms. Chadwick, in her letter, states that most nursing staff are trained in Basic Life Saving (BLS) and that training is expected to be completed this fall. She also states that "Per the enclosed Interim Draft Policy of Emergency Medical Response, the Department at this time is prepared to mandate BLS. The Department is working with representatives from the Massachusetts Psychiatric Society and an Internal Medicine consultant to assess the feasibility of mandating ACLS certification of all medical physicians. The enclosed policy does not limit a facility to BLS and at Worcester, all Internal Medicine physicians have received ACLS training. A final policy will be issued as soon as the MPS completes its study, anticipated later this fall."

As noted in site visits, DPPC investigators found no nursing staff not trained in BLS. As noted above, the Director of Staff Development indicated that 90% of doctors have been BLS-trained, the remaining 10% to be trained by mid-November. As of September 16, 1988, Mr. Rambaran indicated that 50% of physicians were ACLS-qualified. Mr. Rambaran indicated that such training is scheduled outside the institution due to the fact that advanced cardiac equipment is not utilized at Worcester State Hospital.

Action [6]:

"The Chiefs of Nursing, Medicine and Psychiatry and the Director of Medical Records, through a copy of this letter, will report to me for

the case file within 30 days of [August 3], the status of all assigned actions required by this report."

**DPPC Finding:**

The DPPC has received no documentation at the date of this report to support the above statement.

Actions resulting from the death of Mr. C.:

(The DPPC concluded this review of the response to the Worcester deaths on October 7, 1988, the same day on which the corrective action statement on this death was received by the Commission. Documentation of the implementation of the corrective actions ordered in that statement have since been requested by the DPPC but have not been received as of the date of this report.)

Action [1]:

"The Director of Clinical and Professional Services has instructed the Chiefs of Discipline and the Clinical Directors to ensure adequate documentation, as per discipline specific standards, of all clinically relevant data. The adequacy of documentation will continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization."

**DPPC Finding:**

In the letter from Ms. Chadwick dated October 20 she states that "Ms. Crumlin will provide information relating to medical record keeping by the second week of November".

Action [2]:

The Director of Clinical and Professional Services is to instruct the appropriate Chiefs of Discipline and Clinical Directors to provide training to all appropriate treatment team members regarding standards for adequate and appropriate communication between families and treatment team members. These training sessions are to be documented through Staff Development."

**DPPC Finding:**

As of the date of this report, the DPPC has received no documentation to support the above statement.

Action [3]:

"The Director of Clinical and Professional Services, through a copy of this letter, will report to me for the case file within 30 days of the above date the status of all assigned actions required by this report."

**DPPC Finding:**

The DPPC has received no documentation to support the above statement as of the date of this report.

Actions resulting from the death of Mr. E.:

(The decision and action statement on this death was received by the DPPC on October 3, 1988. The due date set by Ms. Crumlin in her statement for receipt by her of documentation of the actions was October 28 1988. The DPPC concluded this review of the response to the Worcester deaths on October 7, 1988. Documentation of the implementation of the corrective actions ordered in that statement have since been requested by the DPPC but had not been received as of the date of this report.)

Action [1]:

"The Chief of Medicine has instituted a policy and and procedure which requires physicians leaving the hospital to note in a book any patients with acute medical illnesses. The physicians coming on duty are required to review this book in the admissions office."

**DPPC Finding:**

The DPPC has received from DMH none of the documentation it requested to verify this statement.

Action [2]:

"The Chief of Medicine has required a daily progress note on any hospital patient with an active medical problem."

**DPPC Finding:**

The DPPC has received from DMH none of the documentation it requested to verify this statement.

Action [3]:

"A review of this case by the Chief of Medicine led to the determination that the on-call physician did not provide a quality of medical care considered to be optimal. The physician in question has since resigned as of June 30, 1988."

**DPPC Finding:**

The DPPC, as of the date of this report, has received from DMH no documentation to support the above statement. In interviews, three senior DMH management staff stated that this person had resigned.

Action [4]:

"The Director of Nurses will develop a fluid intake/output policy for nursing services and ensure that all nursing staff are trained in and carry out this policy."

**DPPC Finding:**

The DPPC has received from DMH none of the documentation it requested to verify this statement.

Action [5]:

"The Director of Nurses will develop a policy regarding assessment of patients health status and actions to be taken to ensure adequate communication/documentation of changes in status to the physicians and to other nurses at shift changes."

**DPPC Finding:**

In her letter of October 20, Ms. Chadwick states that "Ms. Crumlin and Dr. Barreira are developing a psychiatry Policy Manual which will address medication monitoring, criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to the available for circulation this winter."

Action [6]:

"The Director of Nurses is to review the circumstances surrounding the medication error and take appropriate action, including, at least the following:

"a. review of medication administration policies to ensure they comply with all nursing standards.

"b. ensure that all nursing staff are adequately trained and that they carry out these policies according to applicable standards."

**DPPC Finding:**

In her letter of October 20, Ms. Chadwick states that "Ms. Crumlin and Dr. Barreira are developing a psychiatry Policy Manual which will address medication monitoring, criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to the available for circulation this winter."

Action [7]:

"The legal counsel for Region II will work with appropriate hospital staff to establish a policy and procedures regarding notifying guardians of their final appointment."

**DPPC Finding:**

The DPPC has received from DMH none of the documentation it requested to verify this statement.

Also noted in the action statement by Ms Crumlin:

"The Director of Nurses, Chief of Medicine and Legal Counsel for Region II, through a copy of this memo, are instructed to report to me in writing within 30 days of [October 3], the status of all assigned actions required by this report."

**DPPC Finding:**

The DPPC has received from DMH none of the documentation it requested to verify this statement.

Actions resulting from the death of Ms. P.:

(The action statement regarding the death of Ms. P. is dated October 3, 1988 and the due date set by Ms. Crumlin in her statement for receipt by her of documentation of the actions was November 2, 1988. The statement was received by the DPPC on October 7, 1988, which was the day that the DPPC concluded this review of the response to the Worcester deaths. Documentation of the implementation of the corrective actions ordered in that statement have since been requested by the DPPC but had not been received as of the date of this report.)

Action [1]:

"The Chief of Psychiatry will establish guidelines for psychiatrists regarding frequency of patient contact and evaluation."

**DPPC Finding:**

In her letter of October 20, Ms. Chadwick states that "Ms. Crumlin and Dr. Barreira are developing a psychiatry Policy Manual which will address medication monitoring, criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to the available for circulation this winter."

Action [2]:

"The Chiefs of Psychiatry, Medicine, Nursing will ensure the provision of ongoing training to physicians and nurses regarding the diagnosis of, recognition of, and treatment of E.P.S. Action [extra-pyramidal symptoms], especially those which may result in a medical emergency."

**DPPC Finding:**

The DPPC has received from DMH none of the documentation it requested to verify this statement.

Action [3]:

> "The Director of Clinical & Professional Services has instructed the Chiefs of Discipline and the Service/Clinical Directors to ensure adequate documentation of all clinically relevant data. The adequacy of documentation will continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital P.S.O."

**DPPC Finding:**

> Ms. Chadwick, in her letter dated October 20, states that "Ms. Crumlin will provide information relating to medical record keeping by the second week of November".

Ms. Crumlin added the following at the end of the statement regarding Ms. P.:

> "Through a copy of this decision letter, all staff monitored in the action section above are to provide me within 30 days of the receipt of this letter, a report outlining how the assigned actions were accomplished."

**DPPC Finding:**

> The DPPC has received from DMH none of the documentation it requested to verify this statement.

## CONCLUSIONS

Due to the amount of time it has taken DMH to generate recommendations and action statements, and the amount of time it has taken to document implementation, the DPPC has not been able to provide the optimum degree of assessment of the implementation of recommendations for changes as a result of the six deaths at Worcester State Hospital. The overview which has been achieved, while incomplete, nonetheless allows some assessment of the DMH response to the deaths.

Based upon information from documentation which has been available, site visits, and interviews, the Department of Mental Health is apparently making progress toward implementing the majority of recommendations made. However, DMH is taking considerably more time to accomplish these changes than originally estimated by all parties involved.

DMH regulations on investigations (104 CMR 24.00) specify that a decision by the person in charge is to be made within 5 business days of completion of the investigation report (absent extensions granted). The DMH investigations of the deaths were completed in April and the last of the decision statements was dated October 3, 1988, resulting in an average of 10 months from death of patient to action statement. The DPPC has no documentation that extensions were granted. It should be noted that, although Ms. Crumlin was not the Chief Operating Officer at Worcester State Hospital at the time of the deaths, the investigation reports were completed prior to Ms. Crumlin assuming the position. As noted, if the fact of Ms. Crumlin's newness in the position affected her ability to complete the action statements in the required time period, extensions were available.

This delay in completing the action statements and their recommendations obviously affected the completeness of this report, as evidenced by the fact that several of the tasks set out by Ms. Crumlin in the action statements are not yet due at the time of this report, more than 10 months after the last of the six deaths.

### Adequacy of the DMH Investigations and Reports

Upon review of the full DMH investigation reports including appendices and interview summaries, the DPPC can find no evidence that further investigation of the events of the individual deaths would produce any additional useful information. The investigation reports are consistent with

information found and documented in the appendices and interview summaries.

Consistency of Proposed Actions in Relation to DMH Investigation Findings

The decision and action statements issued by Ms. Crumlin, while tardy in relation to the regulatory time requirements, relate consistently to the findings of each of the six investigation reports. The action statements, as written, specifically address the investigators' findings.

Adequacy of Proposed Actions

As written, the proposed actions adequately address the findings of the investigation reports and, consequently, address the specifically-cited faults at Worcester State Hospital which led to the deaths of these six clients.

Adequacy of Implementation of Proposed Changes

As noted above, at this time, based on the documentation and evidence available, the DPPC has been prevented from assessing accurately and completely the implementation of the proposed changes resulting from the six deaths. Despite this fact, it is clear that substantial progress is being made toward the proposed changes, as noted in the body of this report. The proposed changes, particularly those written by Ms. Crumlin, provide for very specific actions to be taken which should significantly improve the level of services at Worcester. However, due to the late receipt of three of the action statements, the DPPC is precluded from fully assessing nearly one-half of the changes which are proposed. Further, the failure or inability of DMH to provide documentation requested by the DPPC in a timely fashion makes accurate assessment of the proposed changes virtually impossible. Specific requests were made by the DPPC for particular documents noted in Ms. Crumlin's action statements. Many of these documents were not received and the responses to these requests do not even acknowledge the request or the existence of the document. While the material may still be forthcoming, the fact that DMH has not yet provided it severely hampers efforts to evaluate their performance, and this failure to provide documentation is not reassuring.

DMH Response to DPPC Requests for Information

It is clear from some of the documents received by the DPPC that these documents were completed substantially prior to the time when DMH provided it to the DPPC. For example, the corrective action statement on the

death of Mr. C. was requested by the DPPC in a meeting with Linda Crumlin on July 20, 1988. A second request was made on September 21, 1988. The decision and action statement was eventually received by the DPPC on October 7, 1988. The document is dated August 22, 1988.

Further, some of the materials requested have not yet been made available, e.g., requests to view documentation on the ordering of medical equipment have been made on four occasions. Initially, Assistant Commissioner Lou Berman indicated that this material was available in his office. However, after several attempts to schedule appointments to view the materials, the DPPC investigator was told that this material was not at that location.

As noted in the body of this report, some of the materials requested, which, according to Ms. Crumlin's decision and action statements, were to have been completed and sent to her within 30 days of the date of her statement (August 3, 1988), have not yet been received by the DPPC. While Ms. Chadwick's responses do not acknowledge the requests, she does refer to dates in November for receipt of documentation.

In the DPPC's initial recommendations on three Worcester deaths (May 19, 1988 - see Appendix) the Commission recommended, because DMH "does not routinely investigate client deaths where the cause of death is determined to be natural causes", that the DPPC should be notified of all client deaths, natural or otherwise, at the time of the original report. In Commissioner Murphy's response to this recommendation, dated August 25, 1988, he stated

> "We concur with this recommendation and will issue to the Commission a written copy of each death report as it is received by the Division of Hospital Management. This will be issued through the Office of Internal Affairs."

In the September 20 DPPC request for documentation, it was requested that documentation be provided indicating "That the DPPC has been provided with a report of each patient death who has died at Worcester State Hospital since August 25, 1988."

The Commission's Executive Director was verbally informed by Ms. Fay in early November that DMH has been forwarding reports of all deaths to the DPPC since August 25, 1988 and will continue to do so. No written response to the September 20 request has yet been received by the DPPC.

## RECOMMENDATIONS

1. The Commission staff recommends that the Commission receive copies of all death reports received by the Department of Mental Health, including state hospitals, mental health centers, community programs and any other death report sent to the Department. Death reports should be called in to the Commission's hotline at the time the death is discovered.

2. The Commission staff recommends that a further review be conducted by the DPPC regarding the specific action statements not completely reviewed by this investigation.

3. The Commission staff recommends that a further investigation be conducted into the ordering of medical equipment at Worcester State Hospital.

4. The Commission staff recommends that a review be conducted by the DPPC at a later date of the status of other DMH state hospitals with regard to the systemic recommendations made by the DPPC, the Joint Committee on Human Services and Elder Affairs, Secretary Johnston, and DMH.

5. The Commission staff recommends that a further request be made to the Department of Mental Health to provide the Commission with documentation demonstrating that medical doctors at the Department's other state hospitals have been trained in BLS and ACLS and that direct care staff in those facilities are receiving CPR training.

## APPENDIX

1. February 19, 1988 memo from Secretary Johnston to Agency Heads

2. May 19, 1988 letter from DPPC Commissioners to Secretary Johnston

3. August 8, 1988 letter from Sen. John Huston and Rep. Paul Kollios to Commissioner Murphy

4. Decision and action statements from Linda Crumlin to complaint parties:

- August 3, 1988, 02-87-WOSH-086, re: Mr. H.
- August 3, 1988, 02-87-WOSH-103, re: Ms. J.
- August 3, 1988, 02-87-WOSH-089, re: Mr. M.
- August 22, 1988, 02-87-WOSH-099-106, re: Mr. C.
- September 28, 1988, 02-88-WOSH-125, re: Mr. E.
- October 3, 1988, 02-88-WOSH-126, re: Ms. P.

5. DMH Manual on Investigations, p. 25

6. DMH Manual on Investigations, p. 38-39

7. June 3, 1988 letter from Secretary Johnston to DPPC Commissioners

8. August 25, 1988 letter from Commissioner Murphy to Alexander Fleming, DPPC

9. September 20, 1988 letter from Larry Wheeler, DPPC, to Linda Crumlin

10. October 20, 1988 letter from Dale Chadwick, DMH, to Larry Wheeler, DPPC

11. DMH regulations 104 CMR 2.11(8) re: emergency first aid kits

12. DMH regulations on investigations, 104 CMR 24.05(4) re: Person in Charge decision

13. DMH regulations on investigations, 104 CMR 24.12 re: extensions of time

14. July 13, 1988 letter from Larry Wheeler, DPPC, to Linda Crumlin

15. September 7, 1988 letter from Larry Wheeler, DPPC to Linda Crumlin

16. September 14, 1988 memo from Ann Marie Jarvey, DMH, to Larry Wheeler

17. September 20, 1988 letter from Larry Wheeler, DPPC, to Ann Marie Jarvey, Worcester State Hospital

18. September 21, 1988 letter from Larry Wheeler, DPPC, to Linda Crumlin

19. September 28, 1988 letter from Ann Marie Jarvey, DMH, to Larry Wheeler

# The Commonwealth of Massachusetts

## Disabled Persons Protection Commission

Two Boylston Street
Boston, Massachusetts 02116

Appendix 2



ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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BY HAND

May 19, 1988

Philip W. Johnston, Secretary
Executive Office of Human Services
One Ashburton Place
Boston, MA 02108

Dear Secretary Johnston:

As you know the Disabled Persons Protection Commission has completed its review of the investigations of three deaths at Worcester State Hospital and three deaths at Bridgewater State Hospital. We thank you for making these reports available to us. As a result of our review we have formulated certain recommendations which we believe will significantly improve the quality of care and treatment received at these and other facilities.

In reviewing the reports of both the Department of Mental Health and the Executive Office of Human Services we have noted the work of the investigators to be extraordinarily thorough and detailed. It is very clear that the investigators spent a great deal of time and effort on these matters. In particular we would like to commend Carmen Russo of EOHS and Jim White of DMH on the objectivity and thoroughness of their investigations, and the very high quality of their reports.

We agree with the findings, conclusions and recommendations of the investigators, in those instances where such were made. Nevertheless, in reviewing the six cases there are several problem areas that arise that have not been the subject of recommendations or other corrective actions by the relevant agency. These are outlined below together with our recommendations. Also, as noted above, we agree with your investigators and our recommendations are made in addition to, rather than in opposition to, any recommendations offered in those reports.

The Commonwealth of Massachusetts
Executive Office of Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Appendix 1

MICHAEL S. DUKAKIS
GOVERNOR
PHILIP W. JOHNSTON
SECRETARY

MEMORANDUM

TO: Agency Heads

FROM: Philip W. Johnston, Secretary

DATE: February 19, 1988

RE: Emergency Medical Response at State Facilities

In several client death investigations conducted or reviewed by my Investigative Unit, the adequacy of CPR and resuscitation efforts at some state facilities was called into question.

Findings in some of these cases include:

1. facilities did not have a specific team of trained staff to respond to emergency calls;

2. doctors, nurses and other staff were not certified in Advanced Cardiac Life Support (ACLS) or Basic Life Support (BLS) which require annual training and recertification;

3. standard equipment needed to conduct proper CPR was not available; and

4. "crash carts" containing necessary supplies were not properly stocked.

Because these findings raise concerns that state facilities may not be properly prepared to respond to emergency situations, I would ask that you survey the capabilities at each of your facilities and report to me by April 30 your findings, including the standards which are established that facilities must meet and the training programs you conduct in CPR for relevant employees.

1. CPR Training - In four of the six deaths, inadequate CPR responses are indicated, whether by lack of CPR trained personnel or improper administration of CPR by trained personnel. Therefore, the Commission recommends that all medical staff and staff in direct supervisory contact with patients at DMH state hospitals and at the Bridgewater state hospital be thoroughly trained in CPR and recertified on a regular basis.

2. Lack of emergency medical equipment - In the death of one client at Worcester State Hospital, it was noted by the investigators in their report that certain pieces of emergency medical equipment were unavailable to the doctor responding to the emergency. The Commission recommends that all DMH state hospitals and the Bridgewater State Hospital be equipped at all times with the necessary emergency medical equipment that will enable a physician to adequately respond to such medical emergencies.

3. In the death of one client at Worcester State Hospital it was noted in the investigation report that the doctor responding to the emergency was unaware of the meaning of a "Blue Code." In the death of another client at the same facility, the investigation notes that the doctor responding to the emergency was untrained in basic lifesaving techniques and could not take charge nor assist in the emergency. The investigation reports of the same facility also note that psychotropic medications were prescribed by doctors at that facility on a "PRN" or as needed basis; DMH regulations prohibit the use of PRN prescriptions for psychotropic medications. In one Worcester report there is a description of a restraint incident in which a doctor authorized use of the restraint after it had been applied; the description made the episode appear to be in violation of DMH restraint regulations. In another Worcester report it is noted that the doctor in charge of the case was unaware of the criteria and outcomes of placing a client on seizure precautions. The Commission recommends that all medical doctors in DMH state hospitals receive a full and adequate training program in basic lifesaving procedures, on responding to medical emergencies, and in DMH regulations on medication administration and restraint procedures.

4. In all six deaths reviewed it does not appear to be the practice in either Worcester State Hospital or Bridgewater State Hospital to notify the ambulance service at the same time that an emergency medical situation is declared. In four of the six deaths reviewed it appears that several minutes would have been saved, perhaps having an effect on the final outcomes in these cases, if an ambulance service had been notified simultaneously with the declaration of a medical emergency. As noted in item 3 and item 1 above, there appears to be a lack of trained medical staff at these facilities. Immediate notification of an ambulance service would provide a backup contingency if trained staff are not immediately available on site. The Commission recommends that at DMH state hospitals and at Bridgewater State Hospital procedures for declaring a medical emergency include the simultaneous notification of an ambulance service.

5. In three deaths at Worcester State Hospital, two were determined to be due to natural causes and one to accidental causes. A review of the investigation reports indicates that two of these deaths may not have occurred with proper emergency response, care and treatment. The Department of Mental Health does not routinely investigate client deaths where the cause of death is determined to be natural causes. In other circumstances, these cases may not have been investigated, and consequently the problems uncovered by the investigation may not have been revealed until another death occurred. The Commission recommends that it should be notified of all client deaths, natural or otherwise, at the time of the original report.

6. In the case of one of the deaths at Bridgewater State Hospital the investigators conclude that absence of Spanish-speaking clinicians substantially hampered the treatment provided to this client, a conclusion which raises questions about the adequacy of the treatment provided in the last days of this client's life. The Commission recommends that the need for interpreters and communication disorder specialists be assessed at all facilities (including English, foreign languages, sign language for the deaf and hard of hearing, and other communication systems).

We respectfully request that you implement our recommendations as soon as possible. We await your response. We think that, at your discretion, it would be in the public's interest to release these recommendations.

Sincerely,

Kathleen M. Vesey
Chairperson

Barbara Miliaras
Commissioner

Stephen M. Spinetto
Commissioner

cc: Alexander F. Fleming
Larry Wheeler

Appendix 3

The Commonwealth of Massachusetts

JOINT COMMITTEE ON
HUMAN SERVICES AND ELDERLY AFFAIRS

STATE HOUSE, BOSTON 02133

SEN. JOHN P. HOUSTON
SENATE CHAIRMAN
Tel. 722-1485

REP. PAUL KOLLIOS
HOUSE CHAIRMAN
Tel. 722-2291

August 8, 1988



Edward M. Murphy
Commissioner
Department of Mental Health
160 North Washington Street
Boston, MA 02114

Dear Commissioner Murphy:

Thank you for your letter of June 22 and for your assistance to the Committee on Human Services and Elderly Affairs in our review of and response to the investigations at Worcester State Hospital.

As a follow-up to our June 9th hearing, the Committee has identified what seem to us to be some major, systemic problems which are especially important for the Department of Mental Health to address. While these apparent deficiencies have been brought to light recently through the investigations into the deaths at WSH and testimony presented to our Committee, we are assuming that many of these problems are not unique to WSH but exist in other state hospitals and mental health facilities as well. We are concerned to hear that some of the improvements already underway at WSH in response to the investigation results are not currently being planned for other DMH facilities. For instance, Assistant Commissioner Louis Berman stated at our hearing that while doctors at WSH are now required to be trained in basic and advanced life-saving techniques, this step has not been taken on a system-wide basis. We fail to see how the potential for medical emergencies requiring such training could vary significantly from one state hospital to another, and we hope that further tragedies will not be necessary to convince DMH of the need for such measures.

With this concern for system-wide improvement in mind, we are requesting your response to several issues which are identified below. Specifically, we are requesting written information on how these apparent deficiencies are being or will be addressed, or on why the Department disagrees with our identification of a particular problem.

Record Keeping:
At least five of the six investigation reports we received noted serious deficiencies in documentation by staff, including both medical and mental health professionals and direct care staff, of residents' progress, condition and/or treatment. It seems reasonable to conclude - as is also suggested by other testimony we have received - that inadequate note-taking and record-keeping are a far too frequent problem. The reasons for important treatment decisions have been inadequately documented, residents - even when medically ill - have sometimes gone without progress notes for shifts or even days at a time, prescriptions and medical information have been recorded incorrectly, and so on. There needs to be a clear policy for all relevant staff regarding such documentation, and this policy must be enforced by management, perhaps through periodic audits of such records. A peer review system, as has already been discussed, would also help to address this problem as it pertains to documentation by professional employees.

Medication Choice:
Your expert consultants found drug prescriptions in at least three of the cases investigated to be questionable at best. Again, a peer review process would be one way of avoiding such serious errors.

Continuity of Care:
Judging from conclusions reached in one of the investigations, staff at Worcester State Hospital received inadequate preparation for the ward reorganization which took place there. It is incomprehensible that a state hospital resident - particularly one in as tenuous condition as the woman in question - would be moved to a new ward without even a transfer summary or any continuity of staff contact. There must be a firm policy to assure that such handling of resident transfers and staff reassignment will not be tolerated.

Organization of Staff Responsibilities:
The lack of pre-assigned roles to various staff members during emergencies resulted in delays and inefficiency in handling life-threatening situations. Emergency procedures must be practiced regularly and specific roles of staff - with the necessary amount of flexibility - should be planned.

In addition, there appears to be a pattern of vagueness in determining what staff member(s) will take primary responsibility for monitoring a specific resident - particularly when a resident is medically ill - and following other kinds of medical orders such as dispensation of additional fluids. In one case, there was confusion over which staff member was responsible for notifying a resident's daughters of their appointment as guardians, resulting in the daughters' not being notified.

Proper management would ensure that such important responsibilities are not left unassigned or open to varying interpretations.

Material Resources/Physical Plant:
It is our understanding that the availability of emergency medical equipment is being improved, and we again urge that such improvements be undertaken on a system-wide basis and not only at WSH.

We are also concerned about the poor lighting noted at WSH and the deficiencies in fire safety noted at a number of state hospitals. Recent reports have identified building deficiencies with respect to safety codes at all seven state hospitals. Surely, these problems can be rectified through the capital outlay program.

Disciplinary Action:
We do not wish to see direct care staff scapegoated for problems that result, at least partially, from the conditions in which they work and from failures of management. However, there needs to be greater accountability of all levels of staff, including management, for errors in the care of clients entrusted to them. There were a number of indefensible staff actions uncovered by your investigations, and it is not clear whether these have been appropriately addressed. Consumers, families, and advocates frequently express concern to us about improper and/or inadequate staff actions, and we are concerned that there is not a sufficient response when such problems occur.

This list is far from exhaustive, but encompasses some of the major issues we believe must be raised at this time. In addition, we support the specific recommendations outlined by the Disabled Persons Protection Commission in their letter to Secretary Johnston dated May 19, 1988. The improvements proposed therein should be implemented immediately.

We are fully cognizant of the detrimental effect that overcrowding of DMH facilities, along with staffing problems, have on client care. We support the Department's plan to ease overcrowding and end the use of DMH as the provider of last resort; other state agencies must begin to take responsibility for clients whose primary needs lie within their mandates, not within mental health. Appropriate community placements for the numerous residents who do not need to be hospitalized must be aggressively pursued. Such persons should be prioritized for placement in new community residences.

We also recognize the responsibility of the legislature to provide the necessary resources to allow for quality care in the state mental health system, though we must also ensure that new resources are being used efficiently.

At the same time, we are deeply concerned by the seriousness of the deficiencies that have been identified in the care provided at our state hospitals. "Band-aid" solutions have to give way to thoughtful, courageous, major changes which are long overdue. We must demand high-quality care for the vulnerable citizens which DMH serves. Institutional care must involve active, appropriate treatment with the goal of re-integration into the community whenever possible.

Again, thank you for your continuing cooperation in our mutual efforts to improve the care of mentally ill persons in our Commonwealth. We await your response to the issues raised above.

Sincerely,

Sen. John Houston

Sincerely,

Rep. Paul Kollios

cc: Secretary Philip W. Johnston, EOHS
Alexander Fleming, Disabled Persons Protection Commission ✓
Geoffrey Brahmer, Alliance for the Mentally Ill
Stan Goldman, Mental Health Legal Advisors Committee
Steven Schwartz et al, Center for Public Representation
Richard Rowland, Mass. Association for Mental Health
Members, Committee on Human Services and Elderly Affairs

The Commonwealth of Massachusetts

Department of Mental Health

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604

See Appendix 4



TO: Parties to the Complaint

FROM: Linda J. Crumlin
Acting Chief Operating Officer

RE: Case # 02-87-WOSH-086

DATE: August 3, 1988

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On 8/21/87 an investigation was initiated to review the circumstances surrounding the death of a patient which occurred on August 20th, 1987. Based on a review of the investigative report submitted by the Department of Mental Health, Office of Internal Affairs, the following conclusions have been drawn:

1. The patient died on August 20th, 1987 of natural causes, specifically, cardiac arrthymia, secondary to an interventricular septal defect in his heart.

2. The patient had received a physical examination and two EKG's in 1984 and 1986. The results of these exams were within normal limits and yielded no reason for concern about cardiac problems. The staff at Worcester State Hospital had not been made aware of the congenital heart defect of the patient.

3. It was found that there were deficient nursing and physician notes without adequate documentation of the rationale for various medication changes.

4. It was concluded that the staff responded quickly and appropriately to the emergency created when the patient fell face forward on to the floor while standing at the nurses station and was attended by medical and/or direct care staff at all times.

5. It was concluded that the use of a loosely applied two point restraint during the emergency situation was for the patient's safety and that the restraint was appropriate.

6. It was found that not all staff who responded to the emergency situation was certified in CPR/BLS, although it was determined that the lack of the certification had no effect on the outcome of the emergency response.

As a result of this investigation and other related investigations, several actions were taken to address systemic issues.

1. The number of physicians on duty evenings and weekends has been increased to two.

2. Mock blue day drills were initiated and are ongoing on each shift.

3. Continuing training of staff in CPR, BLS, crash carts, airway management and emergency response procedures.

4. Requiring all medical physicians to be certified in both BLS and ACLS.

5. Requiring all licensed nursing staff to be BLS trained.

6. Obtaining additional medical equipment to support emergency response efforts.

Actions specific to this case are as follows:

1. The Director of Clinical and Professional Services has instructed the chiefs of discipline and the clinical directors to ensure adequate documentation of all clinically relevant data. The adequacy of documentation will also continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization.

2. Policy directives have been issued requiring all medical physicians to be certified in basic life support and advance cardiac life support. All nursing staff are to be certified in basic life support. The Chief of Medicine and Chief of Nursing are to provide to the Chief Operating Officer (through the office of staff development) quarterly updates specifying status of certification of all medical physicians and nurses. An initial report for all current medical physicians and nurses is to be submitted to the Chief Operating Officer no later than September 3, 1988. The Office of Staff Development is responsible for tracking and monitoring this training. The Director of Nurses is to work with the Office of Staff Development to establish a training schedule for all nursing staff and specify the date by which all nurses will have been certified in BLS.

Pursuant to D.M.H. regulation 104 CMR 24.05 (4) (a), any party to this complaint may obtain a copy of the report of the investigator upon signing of a non-disclosure statement. Further, any party aggrieved by this decision may, within (10) working days of receipt of this report file an appeal with the D.M.H. Office of Internal Affairs (see attached).

cc: Director of Clinical & Professional Services
Director of Nurses
Dawn Branciforte, Facility Investigator
Director of Medicine
Utilization Review Committee Chairperson
Medical Records Committee Chairperson
Director of Staff Development
Barbara Ahearn, Internal Affairs Office
case file

The Commonwealth of Massachusetts

Department of Mental Health

Appendix 4

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604

TO: Parties to the Complaint

FROM: Linda J. Crumlin
Acting Chief Operating Officer

RE: Case # 02-87-WOSH-103

DATE: August 3, 1988



---

On October 26, 1987 an investigation was initiated into a death of a patient which occurred on October 12th, 1987. Based on a review of the investigative report, the following conclusions have been drawn:

1. It was concluded that the patient was not seen by a medical physician or psychiatrist between September 23rd, 1987 and October 2nd, 1987.

2. It was concluded that the physician observed serious EPS symptoms in the patient on October 2nd, 1987 and immediately took corrective action by discontinuing Haldol, tapering off Cogentin and prescribing Symmetrel.

3. It is concluded that in the four days prior to the patient's arrest, her condition began to deteriorate yet, no medical physician or psychiatrist was alerted or informed about her condition, therefore, no medical assessment of her condition was made.

4. It was concluded that no psychopharmacology consultations were scheduled for the patient.

5. It was concluded that there was inadequate and, for some shifts, non-existent documentation in the patient's medical record, especially between October 8th and October 12th, 1987.

6. It was concluded that direct care and nursing staff responded quickly to the medical emergency and that the first responder nurse attempted to establish an airway, ventilated and performed chest compressions on the patient. However, the patient was not placed on the floor or another hard surface nor did the staff responding realize they had not established an airway. In addition, it was found that finger sweeps of the oral cavity to remove any possible blockage had not been performed.

7. It was concluded that hospital personnel failed to provide the on-call physician with the information regarding emergency codes. It was also concluded that once the physician realized the nature of the code upon arrival, he provided appropriate assessments and interventions.

8. It was concluded that the patient died as a result of aspiration pneumonia and aspiration of food stuffs.

As a result of this investigation and other related investigations, several actions were taken to address systemic issues.

1. The number of physicians on duty evenings and weekends has been increased to two.

2. Mock blue day drills were initiated and are ongoing on each shift.

3. Continuing training of staff in CPR, BLS, crash carts, airway management and emergency response procedures.

4. Requiring all medical physicians to be certified in both BLS and ACLS.

5. Requiring all licensed nursing staff to be BLS trained.

6. Obtaining additional medical equipment to support emergency response efforts.

Actions specific to this case are as follows:

1. The Chief of Medicine and the Chief of Psychiatry have been asked to define with the appropriate Service Directors and Program Directors criteria for medical and psychiatric intervention. In addition, the frequency by which all patients are to be seen by medical physicians and psychiatrists will be established.

2. The Director of Nurses has been asked to retrain nursing staff on criteria for notifying appropriate medical personnel regarding changes in patient's medical or psychiatric condition.

3. The Chief of Psychiatry will specify and define hospital-wide protocol for psychopharmacological consultations.

4. The Director of Clinical and Professional Services has instructed the chiefs of discipline and the clinical directors to insure adequate documentation of all significant events. The adequacy and quality of documentation will also continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization.

5. The Director of Nurses has been instructed to ensure that all licensed nursing personnel receive basic life support training.

6. The Chief of Medicine has developed protocol for physicians outlining the hospital's procedures, code calls and emergency requirements.

7. The Chiefs of nursing, medicine and psychiatry, through a copy of this letter, are instructed to report to me for the case file within 30 days of the above date, the status of all assigned actions required by this report.

Pursuant to D.M.H. regulation 104 CMR 24.05 (4) (a), any party to this complaint may obtain a copy of the report of the investigator upon signing of a non-disclosure statement. Further, any party aggrieved by this decision may, within (10) working days of receipt of this report file an appeal with the D.M.H. Office of Internal Affairs (see attached).

cc: Chief of Medicine
Chief of Nursing
Chief of Psychiatry
Director of Clinical & Prof. Services
Utilization Review Committee Chairperson
Medical Records Committee Chairperson

The Commonwealth of Massachusetts

Department of Mental Health

Appendix 4

Worcester State Hospital
Worcester, Mass. 01604



TO: Parties to the Complaint

FROM: Linda J. Crumlin
Acting Chief Operating Officer

RE: Case #02-87-WOSH-089

DATE: August 3, 1988

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On 9/22/87, an investigation was initiated regarding the death of a Worcester State Hospital patient which occurred on 9/22/87. The investigation was conducted by the Department of Mental Health, Office of Internal Affairs. Based on a review of the investigative report, the following conclusions have been drawn:

1. The patient died on September 22, 1987 as a result of a seizure experienced on September 21, 1987. His death was due to natural causes.

2. At the time of the seizure, the patient was not on seizure precaution status as required by Worcester State Hospital nursing policy.

3. Ward staff did not conduct a patient bed check at 11:00 p.m. on September 21st, 1987 in violation of Worcester State Hospital policy.

4. The patient was appropriately prescribed Tegretol which acts as an anti-seizure medication. However, as a result of conflicting evidence (including missing medication and treatment sheets), the investigation was unable to determine with certainty whether or not the patient had been receiving such prescribed medication to control his seizure disorder in the period just prior to his death.

5. The evidence supports the conclusion that the emergency response was timely, however, the response team failed to establish an airway for a period of approximately five minutes. It was further concluded that the doctor responding to the emergency did not take charge of the "blue day" and offer instructions or orders to the responders as required by the "blue day" procedures. In addition, it was found that the physician responder was not certified in basic life support or advance cardiac life support techniques and interventions.

As a result of this investigation and other related investigations, several actions were taken to address systemic issues.

1. The number of physicians on duty evenings and weekends has been increased to two.

2. Mock blue day drills were initiated and are ongoing on each shift.

3. Continuing training of staff in CPR, BLS, crash carts, airway management and emergency response procedures.

4. Requiring all medical physicians to be certified in both BLS and ACLS.

5. Requiring all licensed nursing staff to be BLS trained.

6. Obtaining additional medical equipment to support emergency response efforts.

Actions specific to this case are as follows:

1. With regard to seizure precaution policies, the Chief of Medicine and the Director of Nurses have been instructed to review the seizure precaution policy to ensure that specific criteria exist which identifies under what circumstances patients with a history of seizures require seizure precautions.

2. With regard to bed check policy, the Director of Nurses has instructed all staff to follow the bed check policy and to document these checks.

3. With regard to medication documentation, the Director of Nurses will retrain all nursing staff in maintaining medication and treatment sheets in a safe and secure setting. In addition, the Director of Quality Assurance has been authorized and instructed to obtain and seal the record of any patient who expires at Worcester State Hospital. The entire medical record and other documents including medication sheets and cardex shall be secured by the medical records department through the Director of Quality Assurance. The Director of Medical Records will develop a policy specifying appropriate procedures for sealing medical records.

4. With regard to monitoring effective level of medication, the Chief of Psychiatry and the Chief of Medicine will ensure that staff physicians are trained regarding the monitoring of the effective levels of medication and that these (sessions) are documented.

5. Regarding the physician who responded to the emergency: Upon review of this case by the Chief of Medicine on 9/29/87, it was found that the physician had not been trained in basic life support or cardiac life support. Therefore,

the physician was assigned to attend training to ensure certification in advanced cardiac life support. ACLS training was not required prior to this incident. As a result of the incident, ACLS training was made mandatory for all medical physicians. The physician received certification in advanced cardiac life support in December, 1987.

6. The Chiefs of Nursing, Medicine and Psychiatry and the Director of Medical Records, through a copy of this letter, will report to me for the case file within 30 days of the above date, the status of all assigned actions required by this report.

Pursuant to D.M.H. regulation 104 CMR 24.05 (4) (a), any party to this complaint may obtain a copy of the report of the investigator upon signing of a non-disclosure statement. Further, any party aggrieved by this decision may, within ten (10) working days of receipt of this report file an appeal with the DMH Office of Internal Affairs (see attached).

cc: Chief of Medicine
Chief of Nursing
Chief of Psychiatry
Dir. Clin and Prof. Services
Dir. of Medical Records
Dir. of Quality Assurance
Dawn Branciforte, Facility Investigator
Barbara Ahearn, Internal Affairs Office
Case file

The Commonwealth of Massachusetts

Department of Mental Health

Appendix 4

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 0160



TO: Parties to the Complaint

FROM: Linda J. Crumlin
Acting Chief Operating Officer

RE: 02-87-WOSH-099-106

DATE: August 22, 1988

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On November 2, 1987 an investigation was initiated regarding the death of a recently discharged Worcester State Hospital patient which occurred on or about October 25, 1987. The investigation was conducted by the Department of Mental Health Office of Internal Affairs. Based on a review of the investigative report, the following conclusions have been drawn:

1. The patient was evaluated for signs of a major mental illness by his treatment team. Their clinical judgement was that the patient did not suffer from a major mental illness but rather a borderline personality disorder. Their treatment plan was consistent with their diagnosis.

2. It was concluded that Worcester State Hospital appropriately assessed the patient's substance abuse problem and provided treatment consistent with the resources available. However, as the treatment team acknowledges these resources were not optimal because Worcester State Hospital is not a substance abuse facility. Worcester State Hospital staff urged the patient to access more extensive and intensive treatment found in an inpatient substance abuse facility and arranged for such transfer. The patient refused to accept placement or to remain at such a facility.

3. It was concluded that, although the patient was absent without authorization twice while on priviledge status, the treatment teams decision to continue to utilize the priviledge system as a therapeutic device to advance the patient's treatment was within the parameters of professional judgement. The investigation concludes that the patient, while at Worcester State Hospital, suffered from occassional bouts of depression and was treated accordingly in individual and group therapy.

Cont'd

4. It was concluded that the patient was regularly observed for any overt evidence of suicidality while a patient at Worcester State Hospital. When necessary, staff placed the patient on close observations, suicide precaution or strict suicide precaution. In all cases, such precautions were taken following episodes of gasoline inhalations by the patient. At other times, when the patient was not under the influence of gasoline, his treatment team assessed his condition and determined he was not suicidal.

5. The investigation concludes that the communication between the treatment team and the patient's family was lacking and inadequate.

6. The evidence supports a conclusion that the decision to discharge the patient was within the parameters of professional clinical judgement.

7. The evidence supports a conclusion that the aftercare arrangements developed by the patient's treatment team were adequate and appropriate in light of the fact that the patient refused treatment at an inpatient substance abuse facility.

8. It was concluded that there was inadequate and in some cases, non-existent documentation in the patient's Worcester State Hospital medical record.

9. It was concluded that the patient commited suicide in October of 1987 by means of inhalation of gasoline vapors. The patient was discharged from Worcester State Hospital nine days prior to this event.

Based on the above conclusions, the following actions have or will be taken:

1. The Director of Clinical and Professional Services has instructed the Chiefs of Discipline and the Clinical Directors to ensure adequate documentation, as per discipline specific standards, of all clinically relevant data. The adequacy of documentation will continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization.

2. The Director of Clinical and Professional Services is to instruct the appropriate Chiefs of Discipline and Clinical Directors to provide training to all appropriate treatment team members regarding standards of adequate and appropriate communication between families and treatment team members. These training sessions are to be documented through Staff Development.

Cont'd

3. The Director of Clinical and Professional Services, through a copy of this letter, will report to me for the case file within 30 days of the above date the status of all assigned actions required by this report.

Pursuant to DMH regulation 104 CMR 24.05 (4) (a), any party to this complaint may obtain a copy of the report of the investigator upon signing a non-disclosure statement. Further, any party aggrieved by this decision may, within 10 working days of receipt of this report file an appeal with the DMH Office of Internal Affairs (see attached).

cc: Director of Clinical and Professional Services
Dawn Branciforte, Facility Investigator
Barbara Ahearn, Director of Internal Affairs
case file
Errol Rambarron, Director of Staff Development
Sarla Patel, M.D., Chairperson of Utilization Review Committee
Lawrence Peterson, Ph.D., Chairperson of the Medical Records Committee
Kevin Preston
Louis Berman

/mf

# The Commonwealth of Massachusetts

## Department of Mental Health

Appendix 4

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604



TO: Parties to the Complaint

FROM: Linda J. Crumlin
Acting Chief Operating Officer

RE: Case # 02-88-WOSH-125

DATE: September 28, 1988

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On January 6, 1988 an investigation was initiated concerning the deteriorated medical condition of a Worcester State Hospital patient who subsequently died on January 14, 1988. The investigation was conducted by the Department of Mental Health Office of Internal Affairs. Based on a review of the investigative report dated 4/2/88, the following conclusions have been drawn:

1. It was concluded that the patient died at the University of Massachusetts Medical Center as a result of respiratory arrest 17 days after being transferred from Worcester State Hospital. It was further concluded that respiratory arrest was due to the consequence of pneumonia with the condition of acute renal failure being significant.

2. It was concluded that on December 25th, 1987 when the patient showed symptoms of a medical crisis, the on-call physician did not implement a comprehensive evaluation to determine the cause of the patient's fever. The evidence supports a conclusion that after the patient was examined by the physician, nursing staff over the next several days failed to identify the seriousness of the patient's condition and consequently did not seek additional medical intervention by a physician.

3. The evidence supports a conclusion that the fluid intake received by the patient at Worcester State Hospital was inadequate to compensate for the dehydration caused by the patient's fever. It was also concluded that there was inadequate and for some shifts, non-existent documentation in the patient's fluid flow sheet.

Cont'd

4. It was concluded that there was no system for physicians to relay to on-coming physicians, concerns about patients with acute medical illnesses. It was also concluded that there was a lack of verbal nursing shift reports between some shifts. In addition, it was found that the nursing staffing level on the ward during the holiday weekend required a nurse from a different ward to leave their ward to dispense medications.

5. It was concluded that a medication error which occurred on December 23, 1987 resulted in the patient receiving a higher dosage of medication than was intended.

6. It was concluded that there was no evidence that the patient had ulcers or sores in his mouth.

7. It was concluded that the patient's generalized rigidity was not related to spinal meningitis.

8. It was concluded that the patient had a documented history of dependent edema of his lower extremities which would manifest itself on some occassions. The Worcester State Hospital direct care staff were aware of the patient's condition and took a reasonable coarse of action to correct it.

9. It was concluded that there was no evidence of any alterations to the medical record.

10. It was found that once the legal process was completed and the guardians were appointed, the guardians were not aware of their appointment.

As a result of these conclusions, the following actions have or will be taken:

1. The Chief of Medicine has instituted a policy and procedure which requires physicians leaving the hospital to note in a book any patients with acute medical illnesses. The physicians coming on duty are required to review this book in the admissions office.

2. The Chief of Medicine has required a daily progress note on any hospital patient with an active medical problem.

3. A review of this case by the Chief of Medicine led to the determination that the on-call physician did not provide a quality of medical care considered to be optimal. The physician in question has since resigned as of June 30, 1988.

4. The Director of Nurses will develop a <u>fluid intake/output policy</u> for nursing services and ensure that all nursing staff are trained in and carry out this policy.

5. The Director of Nurses will develop a policy regarding regular assessment of patients health status and actions to be taken to ensure adequate communication/ documentation of changes in status to the physicians and to other nurses at shift changes.

Cont'd

6. The Director of Nurses is to review the circumstances surrounding the medication error and take appropriate action, including, at least the following:

   a. review of medication administration policies to ensure they comply with all nursing care standards.

   b. ensure that all nursing staff are adequately trained and that they carry out these policies according to applicable standards.

7. The legal counsel for Region II will work with appropriate hospital staff to establish a policy and procedures regarding notifying guardians of their final appointment.

The Director of Nurses, Chief of Medicine and Legal Counsel for Region II, through a copy of this memo, are instructed to report to me in writing within 30 days of the above date, the status of all assigned actions required by this report.

Pursuant to D.M.H. regulation 104 CMR 24.05 (4) (a), any party to this complaint may obtain a copy of the report of the investigator upon signing of a non-disicosure statement. Further, any party aggrieved by this decision may, within ten (10) working days of receipt of this report file an appeal with the D.M.H. Office of Internal Affairs (see attached).

cc: Director of Nurses,
Chief of Medicine
Region II Legal Counsel
Barbara Ahearn
D. Branciforte
Case file

tickler 11/28/88

The Commonwealth of Massachusetts

Department of Mental Health

Appendix 4

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604



TO: Parties to the Complaint

FROM: Linda J. Crumlin
Acting Chief Operating Officer

RE: Case # 02-88-WOSH-126

DATE: October 3, 1988

---

On January 1, 1988 an investigation was initiated concerning the medical emergency suffered by a Worcester State Hospital patient on December 7, 1987 and the patient's subsequent death on January 1, 1988 at an acute care facility. The investigation was conducted by the Department of Mental Health Office of Internal Affairs.

Based on a review of the investigation report dated April 8th, 1988, the following conclusions have been drawn:

1. It was concluded that the cause of death was a result of cardiac arrest suffered while at Worcester State Hospital.

2. It was concluded that the patient experienced severe side effects from her medication and that the side effects were neither adequately monitored or treated.

3. The evidence shows that except for a brief visit by the attending psychiatrist, the patient was not evaluated by a psychiatrist from November 26, 1987 until December 6th, 1987. During this time, a reorganization of Worcester State Hospital occurred in which staff and patients were moved simultaneously.

4. It was concluded that the documentation in the patient's Worcester State Hospital medical record was inadequate in that it did not provide the staff on the patient's new ward with the key indicators, rationale for treatment or the extent of problems experienced by the patient in the last weeks of her life.

5. It was concluded that the blue day/medical emergency was called in a timely fashion and that the initial response was timely as well.

6. The patient was intubated and blood pressure and pulse restored. However, it took approximately 20 minutes for this to be accomplished.

7. It was concluded that both physicians and nursing staff were not clear as to their roles with regard to blue day response. In addition, only a limited numer of staff responding were adequately trained in the use of a crash cart.

As a result of this investigation, as well as other previous cases involving similar circumstances, the following actions have been taken:

1. Mock blue day training has been initiated and occurs on all three shifts.

2. The Director of Medicine is working with staff from the University of Massachusetts Medical Center in order to establish a code team approach to emergency response at Worcester State Hospital and revise emergency medical response policies to reflect this approach.

3. All nursing staff are required to be trained in basic life support level of emergency response. All general medical physicians are required to be trained at an advance cardiac life support level of emergency response.

4. All nursing staff and physicians have been informed of the expectation that they are to provide a basic life support level of response to medical emergency situations.

5. All nursing staff have been trained in the use of content of crash carts.

6. The number of physicians on evenings and weekends has been increased to two.

7. Additional medical equipment has been purchased to support the provision of quality of medical care.

8. Ongoing training of staff in CPR, BLS, crash carts, airway management and other emergency response procedures.

With regard to this case in particular, the following actions will be taken:

1. The Chief of Psychiatry will establish guidelines for psychiatrists regarding frequency of patient contact and evaluation.

2. The Chiefs of Psychiatry, Medicine, Nursing will ensure the provision of ongoing training to physicians and nurses regarding diagnosis of, recognition of, and treatment of E.P.S., especially those which may result in a medical emergency.

3. The Director of Clinical & Professional Services has instructed the Chiefs of Discipline and the Service/Clinical Directors to ensure adequate documentation of all clinically relevant data. The adequacy of documentation will continue to be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital P.S.O.

Through a copy of this decision letter, all staff monitored in the action section above are to provide me, within 30 days of receipt of this letter, a report outlining how the assigned actions were accomplished.

Pursuant to D.M.H. regulation 104 CMR 24.05 (4) (a), any party to this complaint may obtain a copy of the report of the investigation upon signing of a non-disclosure statement. Further, any party aggrieved by this decision may, within (10) working days of receipt of this report file an appeal with the D.M.H Office of Internal Affairs (see attached).

cc: Chief of Medicine
Utilization Review Comm. Chair
Chief of Nursing
Dir. of Clin. & Prof. Services
B. Ahearn
D. Branciforte
M. Bogosian
Case file
Medical Records Committee Chairperson
Chief of Psychiatry

Appendix

Departmental or external members of the profession in question and should be reflected in the investigator's report as an "opinion" of some named source. The primary responsibility of the Investigator is to impartially determine what happened and to relate findings of fact and conclusions to others. By expressing personal opinions on matters of professional judgment the Investigator risks making himself a part of the story and thereby undermines his effectiveness as an impartial arbiter of the facts.

Appendix 6

In an effort to assist PIC's in monitoring the timeframes of Investigations, the Office of Internal Affairs will begin issuing a monthly timeframe report on the status of cases.

ACTIONS UPON RECEIPT OF THE INVESTIGATOR'S REPORT

Upon receipt of the Investigator's Report on a particular complaint, the PIC has five working days in which to act. The first responsibility of the PIC, upon receipt of the Investigator's Report, is to review the factual findings contained in the report to determine their adequacy. The PIC may discuss the report with any persons he/she deems necessary in reaching a decision. The PIC is not required to accept or reject any conclusions or recommendations contained in the report. The PIC's decision at this point only concerns whether the report adequately and accurately reports the facts.

A. Reject the Report In Whole or in Part

- If the PIC determines that the factual findings are inadequate (e.g. key witnesses were not interviewed, key documents were not received, key issues were not addressed) the PIC will send the report back to the Investigator's for further investigation. (Use Form) The Investigator will conduct such further investigation as is necessary and submit a revised report to the PIC within 10 working days.

B. Accept the Report

- If the PIC determines that the factual findings contained in the original or revised investigation report are adequate and accurate the PIC shall accept the report.

C. Determine Actions to be Taken

- The PIC must then decide what if any action to initiate in response to the findings of the report. In cases where the Investigation has uncovered deficiencies on the part of the Department or any of its employees the PIC must act aggressively to resolve such deficiencies. Actions by the PIC might include, for example:

1. Change in policy or procedure
2. Training
3. Disciplinary action, transfer
4. Referral for criminal prosecution

Within 5 working days of receipt of an accepted investigation report the PIC must send to each party, to the Investigator, and to the Office of Internal Affairs, a written dated decision (see model decision) which:

1. Acknowledges receipt and acceptance of the investigator's report.

2. Contains a summary of the findings and conclusions contained in the report.
3. Decides the actions to be taken by the PIC.
4. Informs the parties that they may obtain a copy of the report upon signing an enclosed notice of non-disclosure.
5. Advises the parties of their appeal rights.

The Commonwealth of Massachusetts
Executive Office of Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Appendix 7.

MICHAEL S. DUKAKIS
GOVERNOR
PHILIP W. JOHNSTON
SECRETARY

June 3, 1988

Kathleen M. Vesey, Chairperson
Barbara Miliaras, Commissioner
Stephen M. Spinetto, Commissioner
Disabled Persons Protection Commission
2 Boylston Street
Boston, MA 02116

Dear Commissioners:

Thank you for your letter of May 19 about the investigations of deaths at Worcester State Hospital and at Bridgewater State Hospital. Your laudatory comments about the quality of the investigations and the cooperation you and your able Executive Director have demonstrated in working with my Investigative Unit and DMH Internal Affairs staff are greatly appreciated.

I have forwarded your thoughtful comments and recommendations to Commissioners Murphy and Fair. You are obviously aware that many improvements have already been initiated at these two facilities and I have asked both Commissioners to let me know their responses to your recommendations.

After reviewing these investigation reports, I shared your concerns about the quality of the emergency medical response. As a result, by memorandum of February 19, I asked each EOHS agency head to survey and report to me on the training, equipment and overall emergency medical response capability in their respective agencies. I will keep you informed about further progress we have made in this area.

Once again, thank you for your comments about the investigations and your recommendations which will be the basis for further improvements in the quality of care and treatment clients receive at all of our facilities.

Very truly yours,

Philip W. Johnston
Secretary

cc: Kenneth B. Schwartz
Alexander Fleming

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

WARD M. MURPHY
Commissioner

AREA CODE (617)

Appendix 8



August 25, 1988

Alexander Fleming
Executive Director
Disabled Persons Protection Commission
Two Boylston Street
Boston, Massachusetts 02116

Dear Mr. Fleming:

We have received a copy of your letter, in which you outline six major areas of concern that you wish to be addressed by the Department of Mental Health. The following is a response to each of those concerns.

1. CPR Training

We concur with this recommendation. Presently, CPR training is offered at each facility as part of the orientation program for all new employees, or as part of an on-going educational program. Currently, physicians, many of whom are trained, are not part of this program and we agree that all medical staff should be included or evaluated in this training.

We have devised a plan to address these training needs. By September 1, 1988, at least two persons per shift will be CPR certified. By November 1, 1988 the target is for 50% of all relevant staff to be CPR trained. By January 1, 1989 our goal is that all relevant staff will be CPR trained.

In addition, programs will be set up for the recertification process, where they do not currently exist. Periodic CPR training drills (Code Blue) will be instituted throughout the system.

2. Lack of Medical Equipment

We concur with your recommendation that adequate medical equipment must be available for medical emergencies. Presently, all hospitals have either crash carts, or emergency response kits that include equipment and drugs. These will be reassessed on their adequacy and effectiveness, based on standardized expectations being drafted by the Directors of Nursing from our hospital system.

3. Inadequate Medical Response and Familiarity with DMH Regulations Regarding Psychotropic Medication Administration and Seclusion and Restraint Regulations

We concur with this recommendation, however, we believe a clarification is needed on the issue of DMH regulations regarding the use of PRN psychotropic medication. PRN psychotropic medications can be prescribed, but cannot be used as a chemical restraint. A psychotropic drug used as a chemical restraint must have a separate medication order as well as being documented on the seclusion and restraint form.

Your point is well taken in terms of the necessity of all physicians, as well as physicians in training, to be required to have training in (1) CPR; (2) DMH Seclusion and Restraint regulations; and (3) Violence Management Training and this will be accomplished where not already in place by October 1, 1988.

4. Simultaneous Notification of the Ambulance Service

We concur with this recommendation and will facilitate that this procedure be included in each hospital's emergency plan. We will, in addition, reassess this plan to determine whether we are using the most effective process for our medical emergencies.

5. Notification of the Commission at the Time of a Patient Death

We concur with this recommendation and will issue to the Commission a written copy of each death report as it is received by the Division of Hospital Management. This will be issued through the Office of Internal Affairs.

6. The need for Communication Disorder Specialists and/or Bilingual Staff

Presently we do have bilingual staff who are being utilized. Each facility will be sent a copy of this recommendation and assess their current capacity, we will then devise an appropriate plan to address this need in FY'89.

We hope, as you do, that by continuing to address these shared concerns, we can move more expediently towards optimum care for all our clients.

Sincerely,

Edward M. Murphy

EMM:smh

NP-1s
SMH 08/25/88

cc: Henry Tomes
Lou Berman

# The Commonwealth of Massachusetts

## Disabled Persons Protection Commission

Two Boylston Street
Boston, Massachusetts 02116

Appendix 9



ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

(617) 727-6465 V/TDD
1-800-426-9009 V/TDD
FAX (617) 727-6469

September 20, 1988

Linda J. Crumlin
Acting Chief Operating Officer
Worcester State Hospital
Worcester, Massachusetts 01604

Dear Ms. Crumlin:

Enclosed is a copy of a letter dated August 25, 1988 from Commissioner of Mental Health Edward M. Murphy. In this letter Commissioner Murphy details the Department of Mental Health (DMH) response to six recommendations made by the Disabled Persons Protection Commission (DPPC) to remedy areas of concern at Worcester State Hospital.

Also enclosed are copies of three memos from your office, dated August 3, 1988, outlining actions taken to address systemic issues at Worcester State Hospital arising from Cases #02-87-WOSH-086, #02-87-WOSH-089 and #02-87-WOSH-103.

As regards Worcester State Hospital, please supply this office with documentation to support that action has been taken as described in the above documents, specifically:

1. CPR TRAINING

That as of September 1, 1988 at least two persons per shift have been certified in CPR. Please include also your plans for ensuring that 50% of staff will be CPR trained by November 1, 1988 and that all staff will be CPR trained by January 1, 1989

2. LACK OF MEDICAL EQUIPMENT

That equipment for medical emergencies has been reassessed for adequacy and effectiveness.

3. INADEQUATE MEDICAL RESPONSE AND FAMILIARITY WITH DMH REGULATIONS REGARDING PSYCHOTROPIC MEDICATION ADMINISTRATION AND SECLUSION AND RESTRAINT REGULATIONS

That by October 1, 1988 physicians and physicians in training will be knowledgeable of DMH regulations as regards the administration of psychotropic medication, trained in DMH Seclusion and Restraint regulations and trained in Violence Management.

4. SIMULTANEOUS NOTIFICATION OF THE AMBULANCE SERVICE

That simultaneous notification of the ambulance service has been included in the emergency plan and that the emergency plan itself has been reassessed in terms of its effectiveness.

5. NOTIFICATION OF THE COMMISSION AT THE TIME OF A PATIENT DEATH

That the DPPC has been provided with a report of each patient who has died at Worcester State Hospital since August 25, 1988.

6. THE NEED FOR COMMUNICATION DISORDER SPECIALISTS AND/OR BILINGUAL STAFF

That the need for translators available for patients with communication disorders or patients who do not speak English will be assessed.

7. STAFFING

That the number of physicians on duty evenings and weekends has been increased to two.

8. BLUE DAY DRILLS

That mock blue day drills have been initiated and are ongoing on each shift. Please note the frequency of drills.

9. EMERGENCY PROCEDURES

That staff is being trained in CPR, BLS, crash carts, airway management and emergency response procedures.

10. BLS/ACLS CERTIFICATION FOR MEDICAL PHYSICIANS

That all medical physicians are required to be certified in both BLS and ACLS. Specifically, this office requests a copy of the initial report that was to have been submitted no later that Spetember 3, 1988 to the Chief Operating Officer reflecting the status in certification of all medical physicians.

11. BLS CERTIFICATION FOR LICENSED NURSING STAFF

That all licensed nursing staff are required to be BLS trained..Specifically, this office requests a copy of the initial report that was to have, been submitted no later than September 3, 1988 to the Chief Operating Officer reflecting the status in certification of all nursing staff.

12. IMPROVEMENT IN RECORD KEEPING

A. That the chiefs of discipline and the clinical directors are ensuring adequate documentation of all clinically relevant data and that the adequacy of documentation is being monitored by th Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization.

B. That the Director of Nurses has retrained all nursing staff in maintaining medication and treatment sheets in a safe and secure setting, that the Director of Quality Assurance has been authorized and instructed to obtain and seal the record of any patient who expires at Worcester State Hospital. That the entire medical record and other documents, including medication sheets and cardex will be secured by the medical records department through the Director of Quality Assurance. That the Director of Medical Records has developed a policy specifying appropriate procedures for sealing medical records. Please enclose copies of relevant policy documents.

C. That the Director of Clinical and Professional Services has instructed the chiefs of discipline and the clinical directors to insure adequate documentation of all significant events. That the adequacy and quality of documentation will also be monitored by the Utilization Review Committee and the Medical Records Committee of the Worcester State Hospital Professional Staff Organization.

13. SEIZURE PRECAUTIONS

That the Chief of Medicine and the Director of Nurses have ensured that specific criteria exist that identify under which circumstances patients with a history of seizures require seizure precautions.

14. BED CHECKS

That the Director of Nurses has instructed all staff to follow the bed check policy and to document these checks.

15. MONITORING OF EFFECTIVE LEVELS OF MEDICATION

That the Chief of Psychiatry and the Chief of Medicine have ensured that staff physicians are trained regarding the monitoring of effective levels of medication and that these training sessions are documented.

16. CRITERIA FOR MEDICAL AND PSYCHIATRIC INTERVENTION

That the Chief of Medicine and the Chief of Psychiatry have defined with the appropriate Service Directors and Program Directors criteria for medical and psychiatric intervention. In addition, that the frequency by which all patients are to be seen by medical physicians and psychiatrists has been established, and that medical physicians and psychiatrists have been notified thereof.

17. NOTIFICATIONS FOR CHANGE IN PATIENT STATUS

That the Director of Nurses has retrained nursing staff on criteria for notifying appropriate medical personnel regarding changes in patient's medical or psychiatric condition.

18. PSYCHOPHARMACOLOGICAL CONSULTATIONS

That the Chief of Psychiatry has specified and defined hospital-wide protocols for psychopharmacological consultations and informed appropriate staff thereof.

We hope to conclude our investigation shortly and intend on including your responses and documentation in our report. Consequently, a response by October 4, 1988 would be appreciated. Thank you for your cooperation.

Sincerely yours,

Larry Wheeler
Director of Investigations
Disabled Persons Protection Commission

cc: Alexander F. Fleming

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

EDWARD M. MURPHY
Commissioner

AREA CODE (617)



August 25, 1988

Alexander Fleming
Executive Director
Disabled Persons Protection Commission
Two Boylston Street
Boston, Massachusetts 02116

Dear Mr. Fleming:

We have received a copy of your letter, in which you outline six major areas of concern that you wish to be addressed by the Department of Mental Health. The following is a response to each of those concerns.

1. CPR Training

We concur with this recommendation. Presently, CPR training is offered at each facility as part of the orientation program for all new employees, or as part of an on-going educational program. Currently, physicians, many of whom are trained, are not part of this program and we agree that all medical staff should be included or evaluated in this training.

We have devised a plan to address these training needs. By September 1, 1988, at least two persons per shift will be CPR certified. By November 1, 1988 the target is for 50% of all relevant staff to be CPR trained. By January 1, 1989 our goal is that all relevant staff will be CPR trained.

In addition, programs will be set up for the recertification process, where they do not currently exist. Periodic CPR training drills (Code Blue) will be instituted throughout the system.

2. Lack of Medical Equipment

We concur with your recommendation that adequate medical equipment must be available for medical emergencies. Presently, all hospitals have either crash carts, or emergency response kits that include equipment and drugs. These will be reassessed on their adequacy and effectiveness, based on standardized expectations being drafted by the Directors of Nursing from our hospital system.

3. Inadequate Medical Response and Familiarity with DMH Regulations Regarding Psychotropic Medication Administration and Seclusion and Restraint Regulations

We concur with this recommendation, however, we believe a clarification is needed on the issue of DMH regulations regarding the use of PRN psychotropic medication. PRN psychotropic medications can be prescribed, but cannot be used as a chemical restraint. A psychotropic drug used as a chemical restraint must have a separate medication order as well as being documented on the seclusion and restraint form.

Your point is well taken in terms of the necessity of all physicians, as well as physicians in training, to be required to have training in (1) CPR; (2) DMH Seclusion and Restraint regulations; and (3) Violence Management Training and this will be accomplished where not already in place by October 1, 1988.

4. Simultaneous Notification of the Ambulance Service

We concur with this recommendation and will facilitate that this procedure be included in each hospital's emergency plan. We will, in addition, reassess this plan to determine whether we are using the most effective process for our medical emergencies.

5. Notification of the Commission at the Time of a Patient Death

We concur with this recommendation and will issue to the Commission a written copy of each death report as it is received by the Division of Hospital Management. This will be issued through the Office of Internal Affairs.

6. The need for Communication Disorder Specialists and/or Bilingual Staff

Presently we do have bilingual staff who are being utilized. Each facility will be sent a copy of this recommendation and assess their current capacity, we will then devise an appropriate plan to address this need in FY'89.

We hope, as you do, that by continuing to address these shared concerns, we can move more expediently towards optimum care for all our clients.

Sincerely,

Edward M. Murphy

EMM:smh

NP-1s
SMH 08/25/88

cc: Henry Tomes
Lou Berman

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

EDWARD M. MURPHY
Commissioner

Appendix 10

October 20, 1988

Mr. Larry Wheeler
Director of Investigations
Disabled Persons Protection Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Wheeler,

I am working with Linda Crumlin, Acting Chief Operating Officer at Worcester State Hospital to respond to the issues your raise in you letter of September 20, 1988. I regret that we do not have all the documentation you requested at this time. Following is a summary of what we have, and when we expect to be able to provide you with complete information:

1. Two persons per shift have been trained in CPR. Ninety-seven percent of all licensed staff have been trained, all physicians have been trained and two of these physicians are present at the hospital 24 hours/day, 7 days/week. Documentation of these sessions and listings of attendees is available at the hospital.

2. The enclosed crash chart checklist is completed and monitored monthly by the nursing staff.

3. Physician training in DMH regulations is ongoing. Ms. Crumlin will provide more detailed information by the second week in November.

4. Please see the enclosed policy, dated July 20, 1988 relating to ambulance notification.

5. We are working with Ms. Fay to ascertain whether every patient death must be reported to the DPPC.

6. Ms. Crumlin is assessing the need for communication disorder specialists. She will provide the results of her assessment by the second week in November.

7. As indicated above, the number of physicians on duty evenings and weekends has been increased to two.

8, 9. Please see the enclosed memo from Louis Berman dated August 8, 1988.

10. Per the enclosed Interim Draft Policy of Emergency Medical Response, the Department at this time is prepared to mandate BLS. The Department is working with representatives from the Massachusetts Psychiatric Society and an Internal Medicine consultant to assess the feasibility of mandating ACLS certification of all medical physicians. The enclosed policy does not limit a facility to BLS and at Worcester, all Internal Medicine physicians have received ACLS training. A final policy will be issued as soon as the MPS completes its study, anticipated later this fall.

11. Almost all of the nursing staff are BLS trained. Ms. Crumlin expects to complete this training this fall.

12. Ms. Crumlin will provide information relating to medical record keeping by the second week in November.

13. Please see the enclosed draft policy regarding seizure precautions. Ms. Crumlin will provide a final policy as soon as it is completed, expected to be the end of November.

14. A draft departmental policy for security (patient bed checks) is being written. This preliminary draft will be circulated this fall. We will forward a copy once it is ready for circulation.

15-18. Ms. Crumlin and Dr. Barreira are developing a Psychiatry Policy Manual which will address medication monitoring, criteria for evaluation, changes in patient status and psychopharmacy consultations. This is expected to be available for circulation this winter.

I regret that there is a delay in completing our responses. We will forward the additional material to you as noted above. Please do not hesitate to contact me in the meantime.

Sincerely,

Dale Chadwick
Deputy Assistant
Commissioner

cc: Ms. Crumlin
Ms. Fay
Mr. Berman

enclosures

| DMH - HOSPITAL MANAGEMENT POLICY DIRECTIVE | Policy Directive #: HMPD-400 |
|---|---|
| | Date of Issue: |
| TITLE: Emergency Medical Response Interim Directive | Effective Date: |
| | Review Date: |

Compliance Manager: Title
Director of Nursing

Approval: Title — Signature — Date
Assistant Commissioner
for Hospital Management

I. Directive: To comply with these interim standards identifying an initial response to an Emergency Medical situation. This level of response will be Basic Life Support (BLS). BLS is one component of an Emergency Medical Response System.

II. Purpose:

[1] To ensure that patients in need of an Emergency Medical response will be supported through the intervention of Basic Life Support techniques and that such response is performed to a consistent and timely standard of practice.

[2] To ensure procedures are developed that simultaneously activate increased interactions with a more comprehensive Emergency Medical Support System.

III. Policy Cancellation:

This interim directive is to supercedes the requirements identified in the DMH, Inpatient Facilities Operations Manual (IFOM), February 1, 1984; Section IV.B: Emergency Medical Services.

IV. Requirements: The Chief Operating Officer will:

[1] a. Ensure that all physicians and nurses of the hospital staff are trained in BLS. In addition, an appropriate number of direct care staff will be trained in BLS to ensure that there are two (2) direct care staff trained on each ward and present on each shift. Once staff are identified, establish a training program that provides initial certification and every twelve months thereafter, recertification in Basic Life Support. The target goal shall be to have fifty percent (50%) of all identified staff BLS trained by November 1, 1988 and by January 1, 1989 to have all remaining identified staff trained. The Personnel Department or Staff Development Department will be responsible for maintaining the documentation necessary for scheduling and verifying all the identified appropriate staffs participation in the initial and recertification training.

| POLICY DIRECTIVE TITLE: Emergency Medical Response Interim Directive | Policy Directive #: HMPD-400 |
|---|---|

b. Identify an additional response mechanism called "Code Team" to responded to Emergency Medical Response codes. The team will consist of the physician on duty and designated nursing staff. The physician upon arrival then assumes the responsibilities of assessing and directing the interventions of the Emergency Medical Response.

c. The Cardio-Pulmonary Resuscitation (CPR) training may currently be to either the American Red Cross or the American Heart Association standard. It is anticipated that one standard method will be adopted and time phased into future programs.

[2] Establish an internal communications notifications procedure that immediately notifies specific "Code Teams" of the need for an Emergency Medical Response. This will normally be done by establishing a "code alert" and announced over the paging system. Establish a procedure mechanism that ensures that an ambulance is called immediately after the announcement of a "code alert". This external service will transport the patient to an appropriate medical hospital if appropriate.

[3] Have posted in prominent places on all units your current Emergency Medical Response Procedures.

[4] a. Conduct 4 Mock Drills quarterly per shift. The location of these drills shall be such as to challenge the response of various unit staffs and "Code Teams". All "Mock Drills" shall be performed on an unannounced basis to create a realistic response process.

b. All Emergency Medical Responses, real or mock, will be systematically reviewed and reduced to writing. These assessments will be used to document the training requirements identified in paragraph [4] a. above and to identify areas or staff that need further training. All assessment and reviews shall identify the time the response started, who responded at what time; who and at what time a real or simulated call for the Emergency Rescue Squad was made and an assessment if the procedural response was in accordance with your specified procedural plans. These assessment documents shall be retained for a period of two (2) years as permanent files of the Chief Operating Officer's Office.

[6] The performance of Basic Life Support does not require the use of any equipment or drugs. If however the hospital develops a list of equipment to support Basic Life Support situations, such equipment must be available in sufficient quantities and locations to be transported to any Emergency Medical Response situation inside the hospital building within one (1) minute of the first responders call for help. Monthly checks of

| POLICY DIRECTIVE TITLE: Emergency Medical Response Interim Directive | Policy Directive #: HMFD-400 |
|---|---|

equipment must be performed by a staff person designated with this responsibility per your procedural document. A form shall be maintained for a period of two (2) years. If developed, these Emergency Response Equipment Kits will not contain equipment or drugs needed to proceed to the next intervention level of ACLS; Exceptions, see paragraph 7.

[7] The hospital organization, may as your option, make a policy decision that the hospitals Emergency Medical Response system will proceed beyond a Basic Life Support level of intervention with internal staff and equipment. If a decision is to internally proceed to a Medical intervention level beyond Basic Life Support, all appropriate training, equipment and procedural requirements must be clearly defined and implemented to ensure complete proficiency of those standards. This decision will not be made on a case by case, or as needed basis, but rather prospectively as an organizational response decision representing a hospital wide, 24 hour policy standard.

V. Applicability:

This policy directive is applicable to all inpatient facilities within the governing body of the Assistant Commissioner of Hospital Management. Full compliance with all requirements of this policy directive and any future policy directive is expected. If full compliance cannot be achieved, Chief Operating Officers must document their efforts and formulate a plan identifying the corrective actions needed to effect the policy directive implementation in its entirety. The corrective plan will then be provided in writing to the Assistant Commissioner for Hospital Management for comment and/or resolution.

VI. Definitions:

[1] Emergency Cardiac Care (ECC) - includes all of the following elements: 1) recognizing early warning signs of heart attack, efforts to prevent complications, reassurance of the victim, and prompt availability of monitoring and treatment aspects of life support; 2) providing immediate BLS at the scene, when needed; 3) providing ACLS at the scene as quickly as possible to stabilize the victim before transportation; and 4) transferring the stabilized victim to an appropriate hospital where definitive medical care can be provided.

[2] Basic Life Support (BLS) - is that particular phase of ECC that either 1) prevents circulatory or respiratory arrest (or insufficiency) through prompt recognition and intervention, early entry into the EMS system, or both, or 2) externally supports the circulation and respiration of a victim of cardiac or respiratory arrest through CPR.

[3] Advanced Cardiac Life Support (ACLS) - includes BLS plus the use of adjunctive equipment, the establishment of an intravenous line, the administration of fluids and drugs, cardiac monitoring, defibrillation, the control of arrhythmias, and postresuscitation care. It also includes establishing the communications necessary to ensure continuing care.

DRAFT



| POLICY DIRECTIVE TITLE: Emergency Medical Response Interim Directive | Policy Directive #: EMED-400 |
|---|---|

Advanced cardiac life support requires the supervision of a physician in person at the scene, directing activities remotely, or directing activities by some other mechanism previously defined by the physician such as standing orders.

[4] Emergency Medical Response - A patient situation in which someone suspects that the patient is in a serious or life threatening cardiac or pulmonary (breathing) disturbance. A person, layman or professional, calls for help in starting the intervention of Basic Life Support.

VII. Specific Statutes and Regulations:

Massachusetts General Laws Chapter 19

VIII. Reporting: Not Applicable

IX. Appendices: None

The Commonwealth of Massachusetts

Department of Mental Health

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604

To: Assistant Directors of Nurses
Ward Supervisors
Head Nurses of 2D, 3D, 4A, 5C, 6A, 7A, 8C

From: Ken Allen, Rn KA

Date: August 8, 1988

Re: Crash Cart Checklists

On a recent Crash Cart check, the daily Crash Cart equipment checklist and the monthly Pharmacy checklist(Appendix #1) were missing from the Crash Carts.

Some were found in the Medication Room and some in the Nurses Station.

Please keep both checklists on a clipboard on the Crash Carts. (See attached copies).

KA/cp
Attachments

cc: Anne Ranaghan
Linda Crumlin
Dr. Bazemore

# CRASH CART EQUIPMENT CHECK

Lester State Hospital | Ward | Month | Year

| Time | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ...sh Cart | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ac Day Code Sheet | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ac Day Code Book | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...P. Board | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...Pole | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...Key | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...thescope & B.P. Cuff | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ourniquets | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ways (3 sizes) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ryngoscope | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...table O2 with Mask | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ion with Catheter | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...L Intact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ress Station Equipment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...rgency Box Lock Intact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ck Bar | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ...ray | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Initial | Signature and Title | Initial | Signature and Title | Initial | Signature and Title | Initial | Signature and Title |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Responsible Person: Licensed Personnel

Procedure:

1. Emergency equipment will be checked daily by the medication nurse on the day shift.

2. After checking the equipment, the licensed person will then sign her/his initials to the "Crash Cart Equipment Check Form" under the appropriate date. The licensed person will then affix his/her initials, name and title to the appropriate space at the bottom of the form.

3. Equipment that is missing or not functioning must be replaced by the end of this shift.

4. At the beginning of each month, the completed "Crash Cart Equipment Check Form" is sent to the A.D.O.N. and a new form is started.

## Appendix No. 1

## CRASH CARTS

Each Crash Cart should contain the following:

1. Top:

_____Blue Day Code Book
_____Clip board with flow sheets
_____Transfer forms to general hospitals
_____Inspection Book
_____CPR Board
_____IV Pole
_____Suction Machine
_____AMBU Bag
_____Stethoscope, B.P. Cuff and three tourniquets
_____Airways (3 sizes)
_____Emesis Basin
_____Laryngoscope
_____Portable oxygen tank with catheter
_____Check off sheet

Drawer 1

| Exp. Date | | |
|---|---|---|
| _____ | Aminophylline 500mg/ 10cc | 1 |
| _____ | Antilirium 2 ml ( physostigmine salicylate) | 2 |
| _____ | Aramine 10mg/ml, 10 ml ampule | 1 |
| _____ | Aromatic spirit of ammonia inhalant | 4 |
| _____ | Atropine sulfate 0.4mg/cc, 5cc-10cc prefilled | 3 |
| _____ | Bacteriostatic water for injection | 1 |
| _____ | Benedryl 50mg/ml | 2 |
| _____ | Calcium Gulconate 10% | 2 |
| _____ | Digoxin 0.5 mg/ml | 1 |
| _____ | Dilantin 100mg syringe prefilled | 2 |
| _____ | Dilantin 250mg syringe prefilled | 2 |
| _____ | Epinephrine 1mg/ml 1:1000 Amp. | 3 |
| _____ | Epinephrine 1:10,000 (0.1mg/cc) syringe | 2 |
| _____ | Furosemide (Lasix) 10mg/ml prefilled 4cc | 1 |
| _____ | Dextrose 50% 50ml syringe | 2 |
| _____ | Glucagon 1mg/ml syringe | 1 |
| _____ | Lidocaine 100mg syringe | 2 |
| _____ | Narcan 0.4 mg/ml syringe | 5 |
| _____ | Sodium Bicarbonate 7.5 % prefilled 50cc syringe | 1 |
| _____ | Solu-Cortef 100mg/2ml | 1 |
| _____ | Valium 10mg/2ml prefilled syringe | |

Drawer 2

| | | |
|---|---|---|
| _____ | Sterile disposable syringe Insulin 100 U. | 2 |
| _____ | Sterile dispolable syringe 3ml | 2 |
| _____ | Sterile disposable syringe 6ml | 3 |
| _____ | Sterile disposable syringe 10 ml | 2 |
| _____ | Sterile disposable syringe 60ml | |
| _____ | Needles for syringes (all sizes) | 2 |
| _____ | Surgical silk sutures 000 | |

Drawer 2 (continued)

| | | |
|---|---|---|
| _____ | Alcohol wipes | 20 |
| _____ | I.V. Sets | 2 |
| _____ | Intracath (medium) | 2 |
| _____ | Angiocath (18G) | 2 |
| _____ | Sterile, disposable forceps | 2 |
| _____ | Venojet (Piggyback with filter for I.V.) | 2 |
| _____ | Bandage 37X37X52 (triangle) | 2 |
| _____ | Ace Bandages | 2 |
| _____ | Types blood specimen tubes (3 of each color) | 5 |
| _____ | Betadine Ointment | |
| _____ | Venojet tubes | 2 |
| _____ | Throat sticks | 4 |
| _____ | Quick Cath | 3 |
| _____ | Blade | |

Drawer 3

| | | |
|---|---|---|
| _____ | Suction catheter 14 G | 2 |
| _____ | Suction Catheter 16 G | 2 |
| _____ | Suction Catheter 18 G | 2 |
| _____ | Stomach tube | 2 |
| _____ | Sterile gauze sponges 4X4 | 8 |
| _____ | Sterile telfa pads | 4 |
| _____ | Gauze bandage (3 each size) | 2 |
| _____ | Adhesive roll 3', non allergic | 1 |
| _____ | Butterflies | 10 |
| _____ | Bandaids | 10 |
| _____ | Bandage scissor | 1 |
| _____ | Lamino padding (8X7 1/2_) | 4 |
| _____ | Adaptor plug | 1 |
| _____ | Endotracheal tubes 7mm, 8mm, and 9mm | 2 each |
| _____ | Yankauer Suction Catheter | 1 |

Bottom Shelf

Exp. Date

| | | |
|---|---|---|
| _____ | Normal saline sterile sol. 250ml bottle | 1 |
| _____ | D5W sterile sol 500ml bottle | 1 |
| _____ | Cut-down set | 1 |
| _____ | Tracheostomy set | 1 |
| _____ | Oxygen mask | 1 |
| _____ | Flashlight (with batteries and bulb reserve) | 1 |
| _____ | Laceration set containing one | |
| | Needle holder | |
| | Scissor | |
| | Tissue forceps | |
| | Gauze sponge | |
| _____ | Finger Splint | 1 |
| _____ | Splints (different sizes) | 4 |
| _____ | Instrument pack containing | 2 |
| | Hemostat | |
| | Scissors | |
| | Forceps | |

AMBULANCE POLICY AND EMERGENCY RESPONSE
WORCESTER STATE HOSPITAL
JULY 20, 1988

At this time the resources at Worcester State Hospital are adequate for an emergency response at the Basic Life Support level (CPR). We do not have a cardiac monitor or defibrillator which are necessary for the safe monitoring of intravenous cardino medications. Physicians and nurses should call 911 directly in the event of a cardiac arrest, respiratory arrest, choking episode, or other immediately life threatening event. The caller should be prepared to provide basic health information to 911 via telephone while the ambulance is being dispatched. BLS procedures including CPR and the Heimlick maneuver should be applied as clinically indicated. The arriving 911 ambulance will have available a cardiac monitor and defibrillator. This equipment will be used by 911 paramedic operating under radio control. Our WSH physician may communicate with the 911 physician as appropriate, but the 911 physician will have responsibility for directing the activities of the paramedics and the transport of the patient.

If outside telephone lines are not available after dialing "9" then proceed to dial 3-2-1 for emergency access to the WSH operator who will dial 911.

911 may be called for any other medical emergency as well as a code. Routine transfers not requiring paramedics or advanced life support equipment should be booked through Bay State Ambulance Company, our contractor.

The Commonwealth of Massachusetts
Department of Mental Health
Worcester State Hospital
Worcester, Mass. 01604

July 19, 1988

Anne Mitchell, M.D.
Dept. of Neurology
University Of Massachusetts Medical Center
55 N. Lake Ave.
Worcester, Ma

Dear Dr. Mitchell:

Today I met with Dr. Healy, Chief of Psychiatry at Worcester State Hospital and Dr. Tonkonogy, our neuropsychiatrist, in an effort to begin to develop some seizure policies for Worcester State Hospital. I am sending to you a written draft based on our discussions. I would appreciate your comments. I am also sending copies of this material to others here at Worcester State Hospital for their input.

I would like to know the official policy of U.M.M.C. regarding seizure precautions and to inquire as to whether you feel it would be important to have a pharyngeal airway or some other similar device at the bedside.

I am also enclosing a draft "Role of the Neurological Consultant" for your comment. This is similar to the policy we have used for members of your department at Monson and Belchertown over the last few years, which is also enclosed for your background information.

Thank you for taking the time to review and comment on this material.

Sincerely,

Patricia H. Bazemore M.D.

P. H. Bazemore, M.D.
Medical Director

c.c. Dr. Barreira
Dr. Healy
Dr. Tonkonogy
Linda Crumlin

PHB/ts

SEIZURE POLICY WORCESTER STATE HOSPITAL DRAFT

Seizure Precautions

All Patients with epilepsy shall be reviewed annually or when clinically indicated by the primary care physician regarding seizure precautions. The patient may be placed on general seizure precautions, specific seizure precautions, or no seizure precautions according to the degree of seizure control and other specific clinical aspects of the case.

Basic Seizure precautions at Worcester State Hospital shall consist of:

1. Side rails up when patient is in bed. May be half side rails if appropriate. Side rails padded if appropriate.

2. Avoid heights

3. Swimming must be physician approved and would normally include 1:1 supervision under the direction of a certified lifeguard.

4. An attendant should be present during bathing or showering. Bathroom set up should minimize injury if a fall should occur.

5. Patient should not be near potentially hazardous machinery.

Policy for Seizure Precautions DRAFT

Purpose:

Responsible Person:

## Procedure

| Action | Rationale |
|---|---|
| 1. Side rails up when patient is in bed. | 1. To ensure safety |
| 2. Side rails may be half side rails if appropriate. | 2. Depending on patient's orientation |
| 3. Avoid heights | 3. Lessen the chance of injury |
| 4. Swimming must be physician approved and would normally include 1:1 supervision under the direction of a certified lifeguard. | 4. Close supervision is needed |
| 5. Attendant should be present during bathing or showering | 5. Ensure prompt attention if a seizure should occur. |
| 6. Bathroom set up should be to minimize injury if a fall should occur. | 6. Ensure adequate safety |
| 7. Patient should not be near potentially hazardous machinery | 7. Ensure adequate safety |
| 8. All patients with epilepsy shall be reviewed annually or When clinically indicated by the primary care physician regarding seizure precautions. | 8. To ensure control of seizures |
| 9. The patient may be placed on General Seizure Precautions | |
| 10. The patient may be placed on specific seizure precautions. | |
| 11. The patient may be placed on no seizure precautions. | |
| 13. Seizure precautions are determined by the physician according to the degree of seizure control and other specific clinical aspects of the case. | |

Seizure Policy for Worcester State Hospital
DRAFT POLICY

Status epilepticus

Patients with status epilepticus (i.e. continuous seizures without intervening conscious intervals) should be transported to U.M.M.C. for evaluation and treatment. Parenteral drugs such as phenobarbital, valium, and dilantin should not be used at Worcester State Hospital

Acute Seizure Policy:

Any Worcester State Hospital patient who has two or more successive seizures in 48 hours or less should be considered at risk for future seizures or status epilepticus. The following measures should be taken for these patients:

1. Basic seizures precautions should be instituted including padded side rails.
2. The patient should be under constant observation until fully awake for three hours or until an evaluation is performed. The evaluation should be carried out by a consulting neurologist either in person or by phone.
3. An EEG should be obtained as soon as reasonably possible.

Change in seizure medications:

Seizure medications should be prescribed in consultation with the neurologist or neuropsychiatrist. Primary care physicians or psychiatrist should generally not change anti convulsants without consultation. It is not necessary to change seizure medications every time a patient has a seizure. Seizure medications should be prescribed according to an overall plan as outlined by the neurologist.

Seizure records

A record should be kept in the chart of each patient with a seizure disorder which describes the nature and time of the episode. A sample seizure recording sheet is attached. This record should be available to the consulting neurologist.

Discontinuation of anticonvulsants

Neurologic consultation should be obtained prior to discontinuation of anti convulsants. An EEG should be done. Seizure precautions may need to be resumed during the period of adjustment.

Prescription of Anticonvulsant Drugs for Psychiatric Purposes

In certain cases anticonvulsant drugs will be prescribed by the psychiatrist for psychiatric purposes. In these cases, the psychiatrist is the accountable physician for monitoring the effects and side effects of the drug; the psychiatrist will sign the monthly order for the drug and will order and follow up on necessary lab tests.

# The Commonwealth of Massachusetts

## Department of Mental Health

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604



To: Assistant Directors of Nursing

From: Anne Ranaghan, RN, ADON
Acting Director of Nurses

Date: July 11, 1988

Re: Basic Life Support Training

Per Linda Crumlin, Acting Chief Operating Officer, memo of 7/6/88, I have been asked to notify licensed nursing staff through the ADON's that basic life support certification is required of all licensed staff.

To date, we have 87 licensed nursing staff certified in CPR and 34 remaining to be trained.

Please make every effort to send staff to trainings held here and to reiterate with staff the need for this certification.

Thank you.

AR/cp

cc: ✓L. Crumlin
CPR File
ADON Corresp. File

The Commonwealth of Massachusetts
Department of Mental Health
WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604



TO: Linda Crumlin, Chief Operating Officer

FROM: Errol Rambarran, Director Staff Development ER

RE: Status Report on Basic Life Support/CPR for Nurses

DATE: July 21, 1988

As requested in your June 30, 1988 Memo, I am submitting an initial report on CPR certification status of all nurses at Worcester State Hospital. Ninety (90) nurses are currently certified - 30 in Continuing Treatment Services, 28 in Acute Treatment Services, and 32 in Psychogeriatric Services. Thirty three (33) nurses need to be certified, representing approximately 25% of nurses - 18 in Continuing Treatment Services, 8 in Acute Treatment Services, and 7 in Psychogeriatric Services.

I have met with Anne Ranaghan, Director of Nurses (Acting), to address the training of the remaining 33 nurses. Enclosed please find: 1) list of nurses trained in CPR; 2) list of nurses not training in CPR. This report has been possible through the efforts of Anne Ranaghan and Connie Proulx.

ER/mb

pc: Lynn Hallback
Anne Ranaghan
Ken Allen

# The Commonwealth of Massachusetts

Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

EDWARD M. MURPHY
Commissioner

AREA CODE (617)





TO: Edward M. Murphy
Commissioner

FROM: Louis H. Barman
Assistant Commissioner L.B.
Hospital Management

DATE: August 8, 1988

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The following information was given to me by Linda Crumlin concerning training at Worcester State Hospital.

Since January 1, 1988 there have been:

49 training sessions for CPR resulting in 288 individuals trained.

19 sessions in crash cart management 71 individuals trained.

1 blue day practice alert per shift per month.

On the specific incident 4 of the 5 licensed nurses responding were BLS certified and the doctor responding was BLS and ACLS certified. The crash carts are checked daily by nursing services and monthly by the pharmacy. Both activities are logged.

LHB:mh

cc: Henry Tomes
Kevin Preston
Linda Crumlin

LHB-6W

Appendix 11

10: continued

(i) Name: Taunton Unit[19] Fn. 19
Area served: Taunton Area
Location: Chambers 2 North and 2 South
Taunton State Hospital Taunton, Mass.
(j) Name: New Bedford Unit
Area served: New Bedford Area
Location: Goss 1 East and 1 West Goss 2 East and 2 West Goss 3 East
Taunton State Hospital
Taunton, Mass.
(k) Name: Plymouth Unit[19] Fn. 19
Area served: Plymouth Area
Location: Goss 4 East and 4 West
Taunton State Hospital
Taunton, Mass.

(3) Superintendent. Pursuant to G.L.c. 19, s. 14C, the Commissioner is authorized to appoint the superintendent of a state hospital or state school or the director or other head of a residential mental health or retardation facility of the Department. The appointee of a state facility under the control of the Department designated in 104 CMR 2.10 shall be the "superintendent" in accordance with the definition in G.L.c. 123, s.1, and within the context of G.L.c. 123, ss. 1 through 37.

11: Emergency Medical Procedures

(1) Authority. The Department is authorized under G.L.c. 19, s. 29(c) to make regulations for the proper operation of facilities providing care and treatment for mentally ill and mentally retarded persons. With regard to mental retardation facilities, 104 CMR 2.11 is applicable only to facilities operated by the Department or specifically identified by the Commissioner. Emergency medical procedures and requirements applicable to other mental retardation programs are set forth in 104 CMR 4.00.[20] 104 CMR 2.11 is promulgated pursuant to this authority. Fn. 20

(2) Emergency Medical Plan. Each superintendent or other head of a facility shall develop an Emergency Medical Plan for his facility which shall conform to the applicable procedures and standards set forth in 104 CMR 2.11. The superintendent or other head of the facility shall submit such plan to the Department for approval.

2.11: continued

(3) Classification of Medical Emergencies. Each emergency medical plan shall contain the following classification system for reporting emergency medical and trauma conditions:

(a) Class A -- "immediately life threatening":

1. severe, profuse bleeding;
2. choking, blocked airway;
3. unconsciousness;
4. cardiac arrest;
5. cardio-vascular accident;
6. fractured skull or spine;
7. severe extensive burns;
8. other similarly severe injuries.

(b) Class B -- "serious, but not immediately life threatening":

1. bone fractures other than skull or spine
2. severe cuts;
3. localized burns;
4. other sudden signs of serious physical illness.

(4) Procedures for Medical Emergencies: Notification.

(a) Any employee who discovers a patient or resident in a class A or class B situation, shall take immediate first aid measures. Simultaneously, another staff person, if available, will request physician assistance by notifying the telephone operator. If a second staff person is not available, the staff member making the discovery will call at the first possible moment.

(b) The staff member requesting physician assistance shall give the operator the following information:

1. whether the injury is class A or class B;
2. building location, ward location, and phone extension;
3. name of patient or resident involved.

(c) Upon receipt of an emergency medical call, the telephone operator shall:

1. repeat each item of information and enter such information on a form prescribed by the Department;
2. immediately contact by beeper the physician on duty from a list posted by the superintendent or other head of the facility in the switchboard area, and communicate all medical information received;
3. contact the nursing supervisor by beeper, relaying the same medical information and dispatching the nurse to the scene of the emergency;

2.11: continued

4. notify the superintendent or other head of the facility or his assistant;

5. await confirmation from the scene of the emergency of the presence of the physician on duty or the nursing supervisor.

(d) If for any reason the physician on duty does not respond to the operator's alert on the beeper, the operator shall immediately attempt to reach the physician on his regular telephone extension. If the physician fails to respond to the telephone, the operator shall inform the nursing supervisor to take charge of the situation to the extent that his or her training and the situation permit. The operator shall then notify by telephone another physician on the grounds of the facility, and shall dispatch such physician to the scene of the emergency.

(e) If notified by the physician on duty or a staff member designated by such physician that a patient or resident is being transferred to a community hospital, the operator shall immediately alert the emergency admitting room of the hospital to expect the arrival of the patient or resident.

(5) Procedures for Medical Emergencies: Emergency Medical Care. The physician on duty and responsible for emergency medical coverage shall:

(a) remain on the grounds of the facility;

(b) carry a beeper which he shall check as soon as he comes on duty;

(c) upon notification of an emergency via his beeper, confirm or cause to be confirmed to the operator that he is proceeding to the scene of the emergency;

(d) immediately proceed to the scene of the emergency, using the emergency vehicle if appropriate, and render emergency care to the patient or resident;

(e) if the situation warrants outside hospital assistance:

1. direct the transfer of the patient or resident to a community hospital, and accompany the patient or resident to such hospital;

2. inform the operator of such transfer, and of the name of the hospital;

(f) if transfer to a hospital is not necessary, the physician shall render all assistance required, including supervising admission to the infirmary unit where indicated, and shall remain responsible for the patient or resident until his condition has stabilized or until the physician is relieved by another appropriate staff member.

2.11: continued

(6) Notification of Family or Guardian. The superintendent or other head of the facility shall keep informed of any medical emergency, and shall promptly inform the family or guardian of the patient or resident of the emergency situation and the individual§s medical condition.

(a) The emergency medical plan shall designate a nurse or pharmacist to assure that the equipment and supplies in the emergency vehicle are checked and restocked each week, to maintain a log of these weekly checks, and to conduct a monthly check of expired drugs, the condition of the equipment, and to maintain a log.

(b) The emergency medical plan shall designate an appropriate employee to be responsible for the maintenance and fueling of the emergency vehicle, and to make provision for a back-up vehicle when necessary.

(7) Training of Personnel.

(a) The superintendent or other head of the facility shall be responsible for training facility personnel in the implementation of the emergency medical plan established under 104 CMR 2.11(2), and in assuring that such plan is utilized effectively.

(b) Physicians with clinical responsibilities at mental health or mental retardation facilities shall participate in an intensive post graduate course in emergency treatment, under the supervision of or approved by the Department. All facility personnel who come in direct contact with patients or residents, other than physicians, shall participate in a program of in-service training in emergency first aid, established under the supervision of or approved by the Department.

(c) Since choking is a frequent occurrence, especially for retarded residents, the superintendent or other head of a facility for the retarded shall train direct care staff to deal with choking. The superintendent or other head of the facility shall indicate in the Emergency Medical Plan, established under 104 CMR 2.11(2), the provisions for training in this area, the staff conducting the training, a timetable for training all direct care staff, and a continuing plan of instruction of new staff as part of their initial orientation.

2.11: continued

(8) Emergency Equipment. The superintendent or other head of the facility or his designee shall assure the availability of basic emergency first aid kits on each ward. The emergency medical plan shall specify thenumber, location and contents of such kits, which shall minimally contain airways, bandages, tourniquet, antiseptics and ambu bags. The emergency medical plan shall designate who shall have access to the kits, and shall further designate a nurse or pharmacist for each unit to check and restock such kits on a weekly basis, and to maintain a log of such checks. Oxygen shall not be included in on-site emergency kits.

(9) Emergency Vehicle. Each facility shall have available at all times a fully equipped emergency vehicle for the exclusive use of the physician providing emergency medical coverage, and which shall contain the following equipment:

(a) folding stretcher;
(b) portable intravenous pole;
(c) resuscitator with spare oxygen tanks;
(d) assorted splints;
(e) blankets and pillows;
(f) an emergency drug and equipment kit.

(10) Emergency Medical Unit.

(a) The superintendent or other head of the facility shall assure that emergency and surgical units in the facility shall have independent emergency equipment.

(b) The emergency medical plan shall include such units' capacity, capabilities, and procedures for admitting and handling emergency cases.

(11) Communication System for Emergencies.

(a) Every facility shall utilize a "beeper" communications system in accordance with Departmental specifications, and the superintendent or other head of the facility or his designee shall train relevant employees in the use and operation of the beepers. The superintendent or other head of the facility shall assure that one beeper is at all times in the possession of a physician and one in the possession of the nursing supervisor or other designated registered nurse. The superintendent or other head of the facility shall, in the emergency medical plan, establish procedures for the transfer

2.11: continued

of beepers among physicians and nurses, which procedures shall provide that the final responsibility for answering emergency calls lies with the physician and nurse in possession of the beepers.

(b) The superintendent or other head of the facility shall assign responsibility for medical emergencies to one physician (physician on duty) and to one registered nurse for each shift for each day to carry out the duties set forth in 104n CMR 2.11. Such responsibility shall be designated on lists which shall be available at all times on the wards and at the central switchboard.

(c) The superintendent or other head of the facility shall assure that an emergency telephone line or extensions is maintained at the facility for the exclusive purpose of reporting emergency situations to the telephone operator.

(12) Agreements with Community Hospitals. The superintendent or other head of the facility shall negotiate, in accordance with guidelines established by the Commissioner from time to time, a written agreement with a nearby community hospital for emergency medical care and treatment of patients and residents, which agreement shall be subject to the approval of the Commissioner. The superintendent or other head of the facility shall select the hospital with the capacity and facilities to provide comprehensive emergency medical care.

## 2.12: Certification of Capability of Self-Preservation[21] Fn. 21

(1) Authority. The Department is authorized under G.L.c. 19, s. 29(a) to make regulations for the operation of facilities providing care but not treatment for mentally ill and mentally retarded persons. 104 CMR 2.12 is promulgated pursuant to this authority.

(2) Meaning of Terms in 104 CMR 2.12. As used in 104 CMR 2.12, unless the context otherwise requires, terms shall have the meanings ascribed in 104 CMR 2.12(2) through 2.12(6).

(3) Applicant. "Applicant" means a person who has applied to become a resident or who is being referred to a group residence.

Appendix 12

24.03: continued

tion, as defined in 104 CMR 24.00, shall forthwith file a complaint, and failure to so file, assist or forward shall be grounds for appropriate disciplinary action.

(3) The person in charge shall insure that any complaint is accurately and completely reduced to writing on a complaint form, as detailed in the Appendix of Forms, attached hereto.

(4) The person in charge may dispose of summarily under 104 CMR 24.04(1) any complaint where the alleged death or incident occurred or the alleged condition last existed more than one year immediately prior to the date on which the complaint is made.

24.04: Initial Action on Complaint

Within five (5) days of receipt or initiation of the complaint:

(1) If the matter complained of involves no dispute as to the facts, or is patently frivolous, or may be resolved fairly and efficiently within the five (5) day period, or if the conditions of 104 CMR 24.03(4) are satisfied, the person in charge shall prepare a written, dated decision. The decision shall explain the essential facts which are not in dispute, why the person in charge believes the matter may be appropriately resolved without the appointment of an investigator and how the matter is to be resolved. The person in charge shall send copies of the decision to the parties, together with a notice of appeal rights, and to anyone else having a direct interest in the matter. After the expiration of the appeal period without appeal by any party, or after the exhaustion of all appeals and subject to the final decision thereof, the person in charge shall promptly take appropriate action and prepare and add to the file a written, dated report of such action taken.

(2) If the matter complained of cannot be resolved pursuant to 104 CMR 24.04(1), the person in charge shall prepare a written, dated appointment of, and give the appointment and the case record (including the complaint) to, an impartial investigator who in the judgment of the person in charge is capable of proceeding with the investigation in an impartial and objective manner but who shall not be:
(a) Any of the persons directly involved in the incident or condition requiring investigation; or
(b) A staff person who works in the same administrative unit as, except a person with direct line authority over, any person described in 104 CMR 24.04(2)(a).

(3) However the matter is initially resolved, pursuant to 104 CMR 24.04(1) or (2), where the client(s) is (are) incapable, the person in charge shall send a copy of the complaint and the decision or appointment to the Human Rights Committee for the facility or program.

24.05: Conduct of Investigation and Subsequent Action

(1)(a) Within ten (10) days of his appointment the investigator shall hold a private, face-to-face conference with the complainant to discuss the complaint except where the complaint has been initiated by the person-in-charge pursuant to 104 CMR 24.03(1).
(b) In scheduling such conference (and again, at the conference, if the complainant appears without an attorney or other legal advocate present and representing him) the investigator shall advise the complainant that:
1. He may be represented by an attorney, legal advocate of any competent lay person of his own choice who is eighteen (18) years of age or older. The investigator shall also advise the complainant of the availability of legal services or other advocates, including, if there is no one else, the Human Rights

24.05: continued

Committee of the facility or program as provided in 104 CMR 24.11.

2. He may tape record the conference and all future conferences, meetings or hearings that he may be party to during the investigation; but that he must notify all other parties not later than the beginning of the meeting or hearing if he intends to so record.

(c) In any case where the complainant or person(s) complained of is a client and is incapable and unrepresented, the investigator shall give the Human Rights Committee notice of the need for representation.

(2)(a) Within fifteen (15) days of his appointment, but only after his conference with the complainant, the investigator shall hold a private, face-to-face conference with the person(s) complained of or thought to be responsible for the incident or condition to discuss the complaint.

(b) In scheduling such conference with such person(s) or with any other witness the investigator shall advise the person(s) or any other witness that:

1. He may be represented by an attorney, union representative, other legal advocate or any competent lay person of his own choice who is eighteen (18) years of age or older;

2. He may tape record the conference and all future conferences, meetings or hearings during the course of the investigation; but he must notify all other parties to such meetings or hearings not later than the beginning of the meeting or hearing if he intends to so record.

3. The employee has an obligation to cooperate in the investigation.

4. Failure to cooperate may result in appropriate disciplinary action.

(3) After making whatever further investigation may seem to him appropriate and within ten (10) days of completing his conferences with the persons involved and within thirty (30) days of his appointment, the investigator shall prepare a written, dated report briefly describing his investigation and containing his findings of fact and such conclusions and recommendations for action by the person in charge as the investigator may wish to make, delivering the same to the person in charge.

(4) Within five (5) days of receiving the investigator's report the person in charge shall review the report and the case record, discuss the matter with any of the persons involved whom he may think appropriate and prepare a written, dated decision which shall either:

(a) Accept the investigator's report in whole or in part, at least with respect to the facts as found, and state a summary of findings and conclusions and the intended action of the person in charge, including disciplinary action against the person(s) responsible for the incident or condition, if appropriate. The person in charge shall send copies thereof to the investigator. The person in charge shall also send copies to the parties, with a notice of the opportunity to request reconsideration pursuant to 104 CMR 24.05(5) and a notice of appeal rights. A copy of the report of the investigator will be available to the parties upon the signing of a non-disclosure statement.

(b) Reject the report for insufficiency of facts as found, and send the matter back to the investigator for further investigation. In that event the investigator shall complete his investigation and deliver a revised report to the person in charge within the following ten (10) days. Upon receipt thereof the person in charge shall proceed again as provided in 104 CMR 24.05(4).

Appendix 13

24.11: continued

officer whenever a client is determined to be incapable. A copy of such notice shall be included in the client's record.
(b) The human rights officer shall maintain a current list of all such clients.
(c) The HRC shall make special efforts to monitor the program's compliance with Department regulations for all such clients. Such efforts shall include regular visits to the residential environment where such clients live, meetings with clients to determine their satisfaction with the program, and inspection of relevant records or other documents.
(d) Upon receipt of any complaint involving such a client, the person in charge shall immediately forward a copy of such complaint to the HRC.
(e) Upon receipt of such a complaint from the person in charge, or at the request of a client, or on its own motion, where appropriate, the HRC shall assist a client in filing a complaint, if necessary, and, where appropriate, the HRC shall use its best effort to see that such client is represented by an independent attorney or legal advocate in order to insure that his interests are adequately protected. A list of such attorneys or advocates shall be maintained by the HRC and made available to any client when requested.

(3) Party to Complaints or Proceedings. Whenever the HRC has reason to believe that the provisions of 104 CMR 24.00 for Department investigation are not being fully complied with, it may, upon written notice to the official before whom the matter is pending, become a party to the complaint or proceeding. As a party it shall receive copies of all reports, plans, appeals, notices and other significant documents relevant to the resolution of the complaint and be able to appeal any finding or decision on the grounds that there has been a violation of 104 CMR 24.00.

24.12: Miscellaneous

(1) Client Protection. The person in charge or any other official before whom a complaint is pending shall take whatever immediate action may be needed to protect the health, safety and sense of security of any client, complainant or witness.

(2) Disqualification of Official.
(a) The person in charge, the investigator or any other official with authority to act on a complaint shall disqualify himself from so acting whenever he concludes that he cannot act on the matter impartially and objectively, in fact or in appearance.
(b) In the event of such a conclusion, the official shall forthwith prepare and forward a written, dated memorandum of his disqualification and the reasons therefor to the next higher official [as set forth in 104 CMR 24.12(2)(c)], who shall, within ten (10) days of receipt thereof, take such steps as are necessary to insure the processing of the complaint in an impartial, objective manner.
(c) For purposes of forwarding a memorandum of disqualification, requesting an extension of time, or protesting a procedural failure of any official in Column 1, the memorandum, request or protest shall be sent to the corresponding official in Column 2:

| Column 1 | Column 2 |
|---|---|
| Investigator | Person in Charge |
| Person in Charge | Chief Operating Officer or his designee |
| Chief Operating Officer or his designee | Commissioner or his designee |
| Hearing Officer | Commissioner or his designee |

24.12: continued

(3) Request for Extension. The investigator, or any other official acting pursuant to 104 CMR 24.00, may secure an extension of any time limit provided herein with the permission of the next higher official as set forth in 104 CMR 24.12(2)(c), upon a showing of necessity and that the delay will not pose a threat to the safety or security of the client. A request for such extension shall be in writing, with copies to the other parties, and shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter. Such request shall be submitted to and acted upon by the next higher official prior to the expiration of the original time limit.

(4) Procedural Irregularities.

(a) Any party may protest the failure or refusal of any official with responsibility to take action in accord with the procedural requirements of 104 CMR 24.00, including the time limits, by filing a written protest which specifies the failure or refusal, with the next higher official as set forth in 104 CMR 24.12(2)(c).

(b) Within ten (10) days of the filing of such a protest, the official with whom it is filed shall take appropriate action to insure that if there is or was a breach of procedure, it is rectified, including, if appropriate, disciplinary action against the official responsible for the breach or by removal of an investigator or hearing officer and the appointment of a substitute.

(5) Legal Effect. 104 CMR 24.00 has been adopted to replace the Department's Guidelines for Investigation. They are promulgated for the internal departmental purposes of assuring and monitoring the investigation and resolution of incidents and conditions alleged to be dangerous, illegal or inhumane. They are mandatory upon Departmental personnel and Department funded programs. It is not the intention of the Department to provide herein an adjudicatory hearing within the meaning of M.G.L. c. 30A, s. 1(1). 104 CMR 24.00 is not intended to constitute an administrative remedy under the doctrine of the exhaustion of administrative remedies or otherwise.

(6) Commissioner's Investigation.

(a) The Commissioner or his designee may at any time direct that a special investigator or investigating team investigate, and report directly to him as to, the facts of an incident, condition, medicolegal death or other matter, and that all regular proceedings be suspended.

(b) The special investigator or team shall comply with the time limits and other procedures for an investigation set forth in 104 CMR 24.05, unless otherwise directed by the Commissioner, but the Commissioner or his designee shall receive the report and take action thereon and the Commissioner or his designee may provide for time extensions consistent with the standards and notice requirements of 104 CMR 24.12(3).

(c) Except in a case where a hearing has already been held before the intervention of the Commissioner's investigation, any party, except an employee described in 104 CMR 24.06(1), aggrieved by any finding, conclusion or recommendation, or lack thereof, in the report may seek to have a hearing before an Impartial Hearing Officer according to the standards and procedures for a further appeal as set forth in 104 CMR 24.07. In such event the investigation report shall take the place of the decision of the Chief Operating Officer or his designee.

(7) Withholding of Reports in Certain Instances. Reports otherwise required by 104 CMR 24.00 to be sent to parties may be withheld whenever, in the determination of the Commissioner or designee, such disclosure would probably so prejudice the possibility of an effective investigation that such disclosure would not be in the public interest.

# The Commonwealth of Massachusetts

Disabled Persons Protection Commission
Two Boylston Street
Boston, Massachusetts 02116

Appendix 14



ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR
(617) 727-6465 V/TDD
1-800-426-9009 V/TDD
FAX (617) 727-6469

July 13, 1988

Linda Crumlin
Acting Chief Operating Officer
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604

Dear Ms. Crumlin:

Per our discussion earlier today I have enclosed a copy of a letter to Representative Paul Kollios which describes our intended plan for evaluating progress in implementing corrective actions at Worcester State Hospital. Thank you for your assistance and for arranging a tour for us on Monday. I look forward to meeting with you on Wednesday.

Sincerely,

Larry Wheeler
Director of Investigations

cc: Alexander F. Fleming

6/29/88

Representative Paul Kollios, Chairman
Committee on Human Services and Elderly Affairs
House of Representatives
State House
Boston, MA 02133

Dear Representative Kollios:

Thank you for your letter of June 15, 1988 and for meeting with me to discuss the Disabled Persons Protection Commission. With respect to our response to the investigations and recommendations that came out of the recent deaths at Worcester State Hospital we plan to take action in two stages: First, we intend to obtain the full scope of recommended and planned corrective actions from the Department of Mental Health. Second, we will evaluate how much progress has been made in implementing these actions, and ascertain the projected time for the Department to accomplish the specific tasks that remain to be done. In this second stage, both DMH and DPPC recommendations will be evaluated. These two stages are described briefly below.

I. In order to establish the scope of corrective actions and plans:

A. The DPPC will conduct interviews with top level managers in the Department of Mental Health and at Worcester State Hospital to ascertain corrective action plans. Interviews will include those managers responsible for setting, implementing and interpreting action plans:

1. Commissioner Edward M. Murphy,
2. Assistant Commisioner Lou Berman,
3. Acting Chief Operating Officer, Linda Crumlin,
4. Chief of Medical Services, and
5. Others as appropriate.

B. DPPC Investigators will obtain copies of all corrective action plans, training programs and other documents as necessary.

II. In order to evaluate the progress toward correcting unsafe conditions and practices:

A. The DPPC Investigations Unit will review the complete DMH investigation files on each of the deaths, including full content of interviews, investigator's notes and document reviews.

B. The decision and action statements (describing the actions DMH will take in response to each investigation) will be reviewed and compared to the findings of the DMH investigators and the results of our review to ascertain gaps in corrective action plans, if any.

C. Each element of the corrective action plans will be evaluated through site visits and observation of both the current status and planned actions.

D. DPPC investigators will assess the level of corrective action accomplished and prepare a report on progress to date, planned progress and likelihood of accomplishment within stated timelines, and degree of risk to clients at that facility.

We are planning to begin our investigation this week and, will be prepared to provide you with a thorough report on our progress on or before August 7, 1988. Please let me know if you have any questions or comments.

Sincerely,

Alexander F. Fleming
Executive Director

cc: Philip W. Johnston, Secretary
Edward M. Murphy, Commissioner

# The Commonwealth of Massachusetts

## Disabled Persons Protection Commission

Two Boylston Street
Boston, Massachusetts 02116

Appendix 15



ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

(617) 727-6465 V/TDD
1-800-426-9009 V/TDD
FAX (617) 727-6469

September 7, 1988

Linda Crumlin
Acting Chief Operating Officer
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604

Dear Ms. Crumlin:

As part of our investigation at Worcester State Hospital, we need to review relevant procedures. Part of this involves a review of certain applicable DMH regulations. Enclosed is a list of questions pertaining to particular regulations. We would appreciate a response to each of these. In our investigation report we intend to include your responses to each question as you state them.

We would appreciate a response by September 23, 1988 in order to include this information in our final investigation report. Please feel free to call me at 727-6465 if you have any questions on this. Thank you for your cooperation, both you and your staff have been very helpful in assisting us.

Sincerely,

Larry Wheeler
Director of Investigations

cc: Alexander F. Fleming

## SECTION 1 - EMERGENCY MEDICAL PLAN

1.A Has an emergency medical plan been prepared by the superintendent of the facility and submitted for approval to the Department in accordance with 104 CMR 2.11(2)?

1.B Are medical emergencies classified according to the following classifications in accordance with 104 CMR 2.11(3)(a&b)?

- Class A - Immediately Life Threatening
- Class B - Serious, but not immediately life threatening.

1.C Is a nurse or pharmacist designated in the Plan to ensure that the equipment and supplies in the emergency vehicle are checked and restocked each week, that a log is maintained of these checks, and that a monthly check is conducted to [check] expired drugs, the condition of the equipment is noted, and that a log is kept for all of the monthly checks in accordance with 104 CMR 2.11(6)a?

1.D Is an appropriate employee designated in the plan to be responsible for the maintenance and fueling of the emergency vehicle, and to make provisions for a backup vehicle when necessary in accordance with 104 CMR 2.11(6)(b)?

1.E Is training for direct care staff in choking procedures addressed in the Plan, to include the provisions for such training, the timetable for training all direct care staff, and a continuing plan of instruction of new staff as part of their initial orientation in accordance with 104 CMR 2.11(7)(c)?

1.F Does the emergency medical plan specify the number, location, and contents of the basic emergency medical kits which must be found on each ward in accordance with 104 CMR 2.11(8)?

1.G Does the Plan ensure that the emergency medical kits contain, at a minimum, airways, bandages, tourniquet, antiseptics, and ambu bags in accordance with 104 CMR 2.11(8)?

1.H Does the Plan designate who shall have access to the kits in accordance with 104 CMR 2.11(8)?

1.I Does the Plan designate a nurse or pharmacist for each unit to check and restock these kits on a weekly basis and to maintain a log of such checks in accordance with 104 CMR 2.11(8)?

1.J Does the Plan include emergency unit capabilities, capacity, and procedures for admitting and handling emergency cases in accordance with 104 CMR 2.11(10)?

1.K Does the Plan establish procedures for the transfer of beepers among physicians and nurses in accordance with 104 CMR 2.11(11)(a)?

1.L Do these procedures provide that the final responsibility for answering emergency calls lies with the physician and nurse in possession of the beepers in accordance with 104 CMR 2.11(11)(a)?

## SECTION 2 - TRAINING

2.A Are all employees trained to render immediate first aid in all of the following circumstances in accordance with 104 CMR 2.11(3)?

- Severe, profuse bleeding?
- Choking, Blocked Airway?
- Unconsciousness?
- Cardiac Arrest?
- Cardiovascular Accident?
- Fractured skull or spine?
- Severe extensive burns?
- Other similarly severe injuries (as listed above)?
- Bone fractures other than skull or spine?
- Severe cuts?
- Localized burns?
- Other sudden signs of serious physical illness?

2.B Are all physicians who are assigned "on-call" duties licensed to drive within the state of MA in accordance with 104 CMR 2.11(5)(d)?

2.C Are all physicians with clinical responsibilities required to participate in an intensive post graduate course in emergency treatment under the supervision of or approved by the Department in accordance with 104 CMR 2.11(7)(b)?

2.D Are all facility personnel who come in direct contact with patients or residents, other than physicians, required to participate in a program of inservice training in emergency first aid in accordance with 104 CMR 2.11(7)(b)?

2.E Is the program of emergency first aid for personnel other than physicians established under the supervision of or approved by the Department in accordance with 104 CMR 2.11(7)(b)?

2.F Are all staff who engage in the direct care of Mentally Retarded patients trained in appropriate procedures to address choking in accordance with 104 CMR 2.11(7)(c)?

2.G Are relevant employees (the physicians and nurses who cover emergency duties) trained in the use and operation of the beeper system? Is this training conducted or delegated by the Superintendent in accordance with 104 CMR 2.11(11)(a)?

## SECTION 3 - RESPONSIBILITIES

3.A Are all employees aware of their responsibility to report Class A and B conditions, of the proper office to report to, and of the components which constitute a full report in accordance with 104 CMR 2.11(4)?

3.B Are all switchboard operators aware of their responsibilities when receiving a report of a Class A or B condition in accordance with 104 CMR 2.11(4)(c)?

3.C Are all personnel who are assigned "physician on call" duties fully aware of their responsibilities to be available and to respond to Class A and B calls in accordance with 104 CMR 2.11(5)?

3.D Has a person been designated to promptly notify the family or guardian of a patient or resident regarding a emergency medical situation and the patient or residents condition on an ongoing basis in accordance with 104 CMR 2.11(6)?

3.E Has the superintendent or a designated head of the facility ensured that one beeper is at all times in the possession of a physician

and nursing supervisor (or other designated registered nurse) in accordance with 104 CMR 2.11(11)(a)?

3.F Has the superintendent or his designee assigned responsibility for "OnCall" medical emergency duties to one physician (Physician On Duty) and to one registered nurse for each shift for each day in accordance with 104 CMR, Paragraph 2.11(11)(b)?

3.G Are all personnel who will perform in, or have performed in, physician and registered nurse on duty positions knowledgable of their responsibility to carry out the duties set forth in 104n CMR 2.117(104 CMR 2.11(11)(b))

3.H Is the responsibility for on-duty personnel designated on lists for each shift of each day? Are these lists available at all times on the wards and at the central switchboard in accordance with 104 CMR 2.11(11)(b)?

3.I Is a written agreement on file providing for the emergency medical care and treatment of patients and residents at a nearby community hospital? Is this agreement approved by the Commissioner? Does this facility have the capability and facilities to provide comprehensive emergency medical care in accordance with 104 CMR 2.11(12)?

## SECTION 4 - EQUIPMENT

4.A Are beepers checked by the "oncall" physician as a matter of procedure immediately upon assuming "oncall" duties in accordance with 104 CMR 2.11(5)(b)?

4.B Does the facility utilize a beeper communication system? Is this system in accordance with Departmental specifications? (104 CMR 2.11(11))

4.C Is a dedicated emergency phone line or extension provided for use in emergency situations only in accordance with 104 CMR 2.11(11)(c)?

4.D Are basic emergency first aid kits on each ward in accordance with 104 CMR 2.11(8)?

4.E Do these kits contain, at a minimum, airways, bandages, tourniquet, antiseptics, and ambu bags in accordance with 104 CMR 2.11(8)?

4.F Is there a prohibition against Oxygen being stored in the emergency first aid kits in accordance with 104 CMR 2.11(8)?

4.G Is an emergency vehicle for the exclusive use of the physician providing emergency medical coverage on hand in accordance with 104 CMR 2.11(9)?

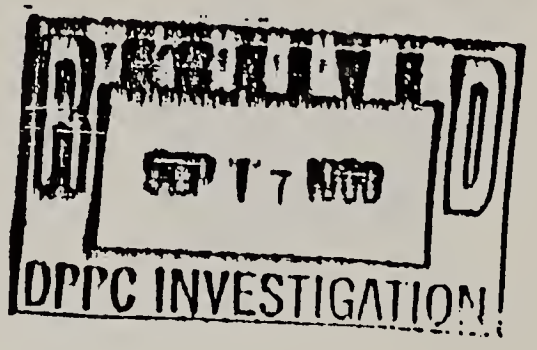
4.H Is the emergency vehicle equipped with a folding stretcher, a portable intravenous pole, a resuscitator with spare oxygen tanks, assorted splints, blankets and pillows, and an emergency drug and equipment kit in accordance with 104 CMR 2.11(9)?

# The Commonwealth of Massachusetts

## Department of Mental Health

Appendix 16

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604




To: Larry Wheeler, Director of Investigations
Disabled Persons Protection Commission

From: Anne Marie Jarvey amj
Acting Director of Quality Assurance

Date: September 14, 1988

Re: Information Request

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Linda Crumlin has requested that I respond to your memorandum of 9-7-88 which outlined several questions concerning the hospital's emergency medical plan, training, responsibilities and equipment. In order to more specifically and accurately address your questions as they apply to Worcester State Hospital procedures I am requesting the following:

1. Your memo to Ms. Crumlin states that these questions stem from your "investigation at Worcester State Hospital". Would you please identify the particular investigation case(s) to which this refers?

2. In order to effectively address your questions, I am requesting an extension of the completion date of this information until Friday, October 14, 1988.

I trust you will respond to these requests in a timely fashion.

/lms

cc: file

# The Commonwealth of Massachusetts

## Disabled Persons Protection Commission

Two Boylston Street
Boston, Massachusetts 02116

Appendix 17



ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR
(617) 727-6465 V/TDD
1-800-426-9009 V/TDD
FAX (617) 727-6469

September 20, 1988

Ann Marie Jarvey
Acting Director of Quality Assurance
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604

Dear Ms. Jarvey:

As we discussed today by phone, I have received your memo of September 14, 1988 concerning particular questions on my memo of September 7, 1988. The questions posed in my memo of September 7, 1988, as you may recognize, are directly extracted from the DMH regulations governing emergency medical procedures, 104 CMR 2.11.

Regarding to which particular cases our questions apply, we are investigating the six original deaths. Two of these cases do not involve emergency medical intervention. However, the remaining four do concern emergency medical procedures.

Regarding the timeline extension, unfortunately our investigation report must be in its final draft by October 7, 1988. If we are to include your responses in our report, we must have them by October 6, 1988.

Thank you for your assistance.

Sincerely

Larry Wheeler
Director of Investigations

cc: Alexander F. Fleming

# The Commonwealth of Massachusetts

## Disabled Persons Protection Commission

Two Boylston Street
Boston, Massachusetts 02116

Appendix 18



ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR
(617) 727-6465 V/TDD
1-800-426-9009 V/TDD
FAX (617) 727-6469

September 21, 1988

Linda Crumlin
Acting Chief Operating Officer
Worcester State Hospital
305 Belmont Street
Worcester, MA 01604

Dear Ms. Crumlin:

As you know we are attempting to finish up our investigation of six deaths at Worcester State Hospital. The focus of this investigation has been on reviewing the corrective action recommendations issued by various parties involved. We have received decision and action statements on three of the six deaths.

Department of Mental Health regulations governing investigations (104 CMR 24.00) state that within five working days of receiving the investigator's report the person in charge shall prepare a written, dated decision (104 CMR 24.05(4)). We request that you forward documentation on whatever waivers or other extensions that have been granted to extend this timeline. If we are to include this material in our final report, it is necessary that we receive it by October 6, 1988.

Please feel free to call me on this matter if you or your staff have any questions. Thank you for your assistance in this matter.

Sincerely,

Larry Wheeler
Director of Investigations

cc: Alexander F. Fleming

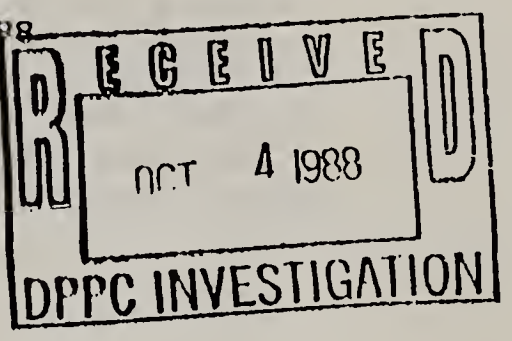
# The Commonwealth of Massachusetts

## Department of Mental Health

Appendix 19

WORCESTER STATE HOSPITAL
WORCESTER, MASS. 01604

September 28, 1988




Larry Wheeler
Director of Investigations
Disabled Persons Protection Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Wheeler,

Please fine enclosed our response to your request for information on September 7, 1988, concerning the emergency medical plan at Worcester State Hospital.

Should you require additional information, please do not hesitate to contact me.

Sincerely,

Anne Marie Jarvey
Acting Director of Quality Assurance

/ir

enclosure

**Preface:**

Worcester State Hospital has had an approved Emergency Medical Plan in effect across hospital departments since 1974. Subsequent annual revisions have been made to the plan and documented. Since 1985, the Emergency/ Disaster Plan of the hospital has been reviewed and revised by individual section in order to comply with new J.C.A.H.O. standards and the requirements as set forth by the Department's Facility Operations Manual. Hospital procedures remain in effect until a formally approved revision is promulgated by the Chief Operating Officer. The Chief of Medicine and Director of Quality Assurance are presently revising the Emergency Medical Plan for the hospital to reflect current J.C.A.H.O. standards, Board of Registration in Medicine regulation and revised Department of Mental Health Policy.

## Section 1 - Emergency Medical Plan

1.A. Yes, and Emergency Medical Services Plan was prepared in responce to these requirements as set forth by the Department of Mental Health, Facility Operations Manual, 1984. The Plan has subsequently been reviewed and modified.

1.B. All Class A conditions are defined in Worcester State Hospital Blue Day Code Policy . However, the Nursing Department and Physicians have established written protocols to respond to each of the class conditions. The Quality Assurance Patient Care Assessment Committee is presently reviewing the response mechanism applied to the reported incidents according to a 'severity of injury' scale.

The Departments of Nursing and Medicine are presently reviewing their Blue Day Code Policies. A consultant has been procured from U.M.M.C. to review our emegency response policies and recommend system changes.

1.C. Yes, all of these requirements are outlined in th Pharmacy and Nursing Service Procedure Manuals. 'Emergency vehicle' is defined at Worcester State Hospital as the crash carts and emergency medication boxes available thoughout the hospital.

1.D. Not applicable

1.E. In order to meet this requirement, the hospital requires all new employees to attend orientation which includes Heimlich Maneuver Training. The Chief of Medicine recently convened a Dysphagia Committee (August, 1988) to conduct a literature and consultant search, to review current Dysphagia procedures in-house and to subsequently develop a dysphagia management policy for the hospital. Nursing has re-trained all of its staff regarding patient feeding; swallowing problems; a problem reporting protocol has been instituted and the menu for certain at-risk populations has been modified. Policies and procedures concerning diet orders and mealtime supervision are presently being revised hospital-wide. Dysphagia consultants have been procured for the hospital and are scheduled for site consultation on September 29th and 30th. Dysphagia management protocols have, also, been received from New York University Medical Center and Cushing Hospital in Framingham. A speech pathologist also, has, recently been hired whose responsibilities will include a role in the choking management plan.

1.E. Yes

1.G. Yes

1.H. Yes

1.I. Yes

1.J. Not applicable

1.K. Nurses are currently not included in the beeper communication system. Physicians are the only staff with beepers for emergency medical response. The hospital's paging communication system is utilized to call nurse responders.

1.L. Physician O.D.s, R.N.S (refer to 3.E.) and ward staff are currently expected to respond hospital-wide.

## Section 2 - Training

2.A. Licensed staff, e.g. R.N., L.P.N., M.D., are trained in BLS level of response; Direct Care Staff receive basic first aid, Heimlich procedures and emergency response tracking during orientation..

2.B. A physician's geographic accessibility to the hospital is considered during the credentials review process according to Worcester State Hospital policy.

2.C. All physicians at Worcester State Hospital are required to have succesfully completed Basic Life Support Training, (BLS).

2.D. Yes, through new employee orientation sessions these requirements are met.

2.E. Yes

2.F. Yes (refer to 1.E.)

2.G. Yes

## Section 3 - Responsibilities

3.A. These reporting systems are included in the Blue Day Code in the policy.

3.B. Yes

3.C. Yes

3.D. Yes

3.E. Refer to 1.K. and 4.A.

3.E. Yes, except that no 'one' registered nurse is assigned per shift per day, rather, all available nursing supervisors are required to respond to Blue Day Codes during their respective shift. (refer to 1.B.).

3.G. Yes

3.H. Physician lists are provided to the switchboard and all hospital wards. Nursing supervisor lists are provided to the switchboard.

3.I. There are written agreements with the closest community hospitals (Worcester Memorial Hospital and U.M.M.C.) which describe the arrangements and procedures for routine and emergency medical/surgical care of Worcester State Hospital patients. Both Community hospitals have comprehensive emergency medical service units.

## Section 4 - Equipment

4.A. Yes, however, the adequacy of the current beeper capabilities, e.g. range and effectiveness is presently being reviewed.

4.B. Yes

4.C. Yes

4.D. Yes, emergency medical boxes are located on each ward with crash carts located on each floor of the residential building.

4.E. The crash carts contain these items.

4.F. Oxygen is available on each crash cart.

4.G. Yes, a vehicle is available through the hospital's security office to transport a physician if necessary. '911' for ambulance response is used if determined as necessary by the physician responder.

4.H. Worcester State has a contractual arrangement with Bay State Ambulance Service in order to meet this requirement, as well as the availability of the '911'service.